NEW ACCOUNT ENROLLMENT MID-SIZE (51-100)

A. ACCOUNT INFORMATION

Account's Legal Name	Doing Business As

Average Number of Employees Employed on Business Days in the Preceding Calendar Year.[1]_____

Number of Employees Enrolling in Group Coverage._____

[1]Please include full-time, part-time, and seasonal employees regardless of hours worked or eligibility for the plan to arrive at the average number of employees. If the average number of employees is less than 51 your business is not eligible for mid-sized group coverage. Please contact your Wellmark authorized representative to get the correct application for your group size.

Effective Date _____/_____/_____

I understand and confirm that the requested effective date is considered a designation of the date as my employer group's plan year and annual renewal date. I understand and agree that the plan year and renewal date will align with the requested effective date.

Account Contact Person	Phone Number	Email Address (optional)

Physical Account Address (For UPS Shipping Non-PO Box)

Street City State ZIP

Billing Address if Different than Physical

Street City State ZIP

☐ Yes ☐ No Will a third party, such as TPA or CPA, be receiving your bill?[2] ☐ an address of the account itself?

[2]By checking yes, I authorize Wellmark, Inc. to deliver, by paper or electronic means, the periodic Wellmark group statement or premium invoice to the billing address described above. I acknowledge the above named Account is responsible for payment of the amount stated in the periodic Wellmark group statement or premium invoices, in accordance with the terms of the Group Insurance policy or Administrative Services Agreement between the Account and Wellmark. The Wellmark group statement or premium invoice delivered periodically to any third party service provider can be viewed by the Account by registering for electronic billing at Wellmark.com. For complete instruction, contact your Wellmark representative. Account may elect to receive an email notification providing Account that a Wellmark group statement or premium invoice is available for viewing.

List carriers offering a health plan option other than Wellmark

B. ADDITIONAL INFORMATION

Coverage Effective Date Waiting Period[3] (See below for definitions on waiting period and eligibility): Please check one.

☐ A - Effective date is date of eligibility if eligibility lands on the 1st day of the month, otherwise, 1st of the month following date of eligibility
☐ B - Effective date is 1st of the month following date of eligibility
☐ C - Effective date is 1st of the month following 30 days of eligibility
☐ D - Effective date is 1st of the month following 60 days of eligibility
☐ E - Variable effective dates, please check one:
  ☐ Effective Date is date of eligibility; or
  ☐ Other_____ Please indicate number of days (waiting period) between eligibility and when coverage begins.

If you want to determine your own eligibility, please contact your authorized Wellmark representative for details. (**for 51-100 groups only**)

☐ Check if the Eligibility Waiting Period will apply at time of initial account enrollment.

[3]**Waiting Period** cannot exceed 90 days from date of eligibility. For a new hire whose eligibility begins on the date of hire, coverage would begin on the selected effective date.
Conditional eligibility: An employee's eligibility can be conditioned on the completion of no more than 1,200 cumulative hours of service, or meeting determined eligibility criteria (such as achieving job-related licensure requirements terms), though these conditions may still subject you to a penalty under IRC 4980(h).

Measurement period: If your organization is using 12 month measurement period to determine the full-time status of employees who work variable hours, coverage must be made effective no later than 13 months from the employee's start date, plus the time remaining until the first day of the next calendar month.

Check if any of the following applies to group:

☐ Group is a public body
☐ Group will offer coverage to part-time employees
☐ Group will offer coverage to retirees (If checked, please provide formal retiree agreement.)
☐ Group will apply a layoff provision (If checked, please provide supporting documentation.)

COBRA Services

☐ Wellmark to provide no COBRA services
☐ Wellmark to provide Standard COBRA Administration Services. If COBRA Administrative Services is checked, a COBRA Administrative Services Agreement (form M-57106) must be completed and attached.

Confirmation of Medicare secondary payer (MSP) status (please complete the Confirmation of MSP Addendum and attach):

☐ The employer understands and acknowledges that the information on the MSP form has been completed to the best of his or her knowledge.
☐ The employer confirms that he or she did receive, read and understand the "Information Regarding the Medicare Secondary Payer Statute" and any questions regarding this information have been answered.

C. COVERAGE INFORMATION

Product Selection: Check products selected: ☐ Health ☐ Dental

Submit the signed Proposed Rate Sheet showing the coverage code(s) for all selected products (health and dental) and rate structure selected.

D. REQUIRED DOCUMENTS CHECKLIST

☐ **CENSUS FILE LISTING** Submit the listing and verify ages, gender, and type of contract and any changes from proposed rate quote. Indicate benefit code, if more than one health benefit is selected.

☐ **PERSONAL DOCTOR SELECTION FORM (PCP) (if applicable)** Submit only when selecting Blue Choice® or Blue Advantage® coverage.

☐ **APPLICATIONS** Send applications for all eligible employees, this includes applications for employees who are waiving coverage.

E. REQUIRED SIGNATURES

By signing this New Account Enrollment form I certify that I am a designated employee or officer of the Employer with the authority to enter into agreements on the Employer's behalf. By signing this agreement and making payment of the required premiums, the employer agrees and certifies that employer:

1. Will comply with all terms and provisions of the Group Insurance Policy issued.
2. Will make the coverage available for all eligible employees and their eligible dependents and distribute notices, documents and information to the enrolled employees as required.
3. Will pay Wellmark by the premium due date, all premium amounts, on behalf of each covered member.
4. Will submit complete applications of employees prior to their date of eligibility and maintain all necessary records regarding employment or eligibility.
5. Has reviewed this entire application and all answers contained herein are true and complete to the best of the employers or authorized representatives knowledge and belief.
6. Confirms all employees applying for coverage are employees of the employer and receive salary or wages documented on state and/or federal payroll reports, and have satisfied any applicable eligible waiting period.
7. Acknowledges receipt of Wellmark rate proposals and that the employer has signed such proposals.

Account Administrator's Signature _____ **Date**_____/_____/_____

I have informed the employer of the employer's obligation under Wellmark's Failure to Disclose penalties. I have attached and reviewed all required documentation. The documentation is complete and accurate for account enrollment.

I am the appointed agent and am receiving commissions for the submission of this client. No portion of my commission payments from Wellmark will be paid to an agent or producer not appointed by Wellmark. I have advised employer that failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or re-rating of the employer's premium.

Selling Agent/Rep Name_____ **Selling Agent/Rep Number** __ __ __ __ __ __ __ __

Agency_____ **Date**_____/_____/_____

Required Federal Accessibility and Nondiscrimination Notice

Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Wellmark does not exclude people or treat them differently because of their race, color, national origin, age, disability or sex.

Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 5W189, Des Moines, IA 50309-2901, 515-376-4500, TTY 888-781-4262, Fax 515-376-9073, Email CRC@Wellmark.com. You can file a grievance in person, by mail, fax or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone or fax at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ສ່ຽງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ຫາ. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, नि:शुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တၢ်နုးသ့ဉ်ညါ–နမ့ၢ်ကတိၤကညီကျိာ်.ကျိာ်တၢ်မၤစၢၤတၢ်ဖံးတၢ်မၤတဖဉ်.လၢတဘဉ်လာ်ဘူးလဲ.ဆိဉ်လၢနဂီၢ်လီၤ.ဆဲးကျိုးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ၢ်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ၢ်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ይሙሉ ያነጋግሩን።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heɓir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojį' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

09/16 A