Application for Individual Health, Dental & Life Insurance

Instructions

- Please print your responses and use a ballpoint pen. Press hard for good copies.
- Be sure that all sections of the application are completed.
- If this application is for children only, the applicant must be the oldest child.
- If the applicant is under age 18, the signature and relationship of a parent or legal guardian is required.
- **Wellmark must receive this application within 15 days of the date you signed it.**

Checklist

- ☐ Did you indicate which health care plan you are applying for and whether or not you wanted optional benefits? *(See Section B, Enrollment Information.)*
- ☐ If you want your premium automatically deducted from your checking account, have you included a voided check?
- ☐ If the person paying your premiums did not sign the application, have you attached a completed pre-authorization form (Form M-5779)?
- ☐ Have you checked yes or no to each health question?
- ☐ Have you completed the tobacco declaration section?
- ☐ If you made any changes to this application, did you initial that change?
- ☐ Have you signed and dated the application?

An Independent Licensee of the Blue Cross and Blue Shield Association

® Registered Marks of the Blue Cross and Blue Shield Association

USAble Life®

®' Registered Mark of USAble Life Insurance Company

Wellmark BlueCross BlueShield of Iowa
An Independent Licensee of the Blue Cross and Blue Shield Association
636 Grand Avenue • Des Moines, Iowa 50309-2565

USAble Life
P.O. Box 1650
Little Rock, Arkansas 72203-1650

Group / Billing Unit No.

Monthly Premium Amount is:

A. Membership Information

☐ Option 1 – Enter an effective date _____ / _____ / _____ ☐ Option 2 – Wellmark assigns effective date

Effective Date

Name (First, Middle, Last)

Marital Status ☐ Single ☐ Married ☐ Common Law (Notarized Affidavit Required)

Address (Include Street, Building Name/No., Apt. No., City, State, Zip)

County No.

Home Phone ( )

Billing Address (Include Street, Building Name/No., Apt. No., City, State, Zip)

Are you a resident of Iowa? ☐ Yes ☐ No

List all persons to be covered.	First	MI	Last	Birthdate	Social Security Number	Height	Weight	Sex	F/T Student 19 or over	Disabled?*
Applicant								☐ Male ☐ Female	☐ Yes	☐ Yes
Spouse								☐ Male ☐ Female	☐ Yes	☐ Yes
Dependent								☐ Male ☐ Female	☐ Yes	☐ Yes
Dependent								☐ Male ☐ Female	☐ Yes	☐ Yes
Dependent								☐ Male ☐ Female	☐ Yes	☐ Yes
Dependent								☐ Male ☐ Female	☐ Yes	☐ Yes

*Is disabled person(s) eligible for Medicare? ☐ Yes ☐ No

B. Enrollment Information

1. Please circle the Health Care Plan you are applying for:

Alliance Select Comprehensive	Alliance Select Enhanced	Alliance Select Essential	HSA	Classic Blue
300 750 1250 1750	600 1200 1800 2400 3000 4200	1500	1550 2550	3000 5000

2. Please indicate Yes or No for each of the following optional benefits:
Contraceptives ☐ Yes ☐ No Blue Dental ☐ Yes ☐ No Supplemental Accident ☐ Yes ☐ No USAble Life Insurance * ☐ Yes ☐ No
**if yes, please complete Section G*

3. Application is for (check all that apply):
☐ New Enrollment ☐ Adding/Removing Dependents ☐ Marriage ☐ Divorce ☐ Medicare Eligibility ☐ Death ☐ Birth
☐ Other, Specify _____
Name of Affected Party(ies): _____ Date of Event: _____ / _____ / _____

4. How do you want to pay your health premiums? ☐ **List Bill through employer**
☐ **Direct Bill.** If so, on what basis? ☐ Quarterly ☐ Semi-annually ☐ Annually Employer name: _____
☐ **Automatic Account Withdrawal.** If so, on what basis? *(Include a voided check.)*
☐ Monthly–1st of the month ☐ Monthly–5th of the month ☐ Quarterly ☐ Semi-annually ☐ Annually
From: ☐ Checking or ☐ Savings **If payor did not sign the application, pre-authorization form M-5779 is needed.**

5. a. Will your employer be paying any part of the premium for this certificate either directly or through wage adjustments or other means of reimbursement? ☐ No ☐ Yes If yes, check one item below:
☐ Applicant is owner of a sole proprietor business ☐ Employer is deducting the full premium ☐ Employee is part-time or temporary and not eligible for small employer coverage
☐ Employer has only one eligible employee ☐ Employer has more than 50 employees
☐ Employer has been denied the opportunity to purchase insurance due to low participation/contribution (attach copy of denial)

5. b. Will your premium payments for this coverage be deductible on your federal income tax return as a trade or business expense other than the special health insurance deduction available to self-employed persons? ☐ No ☐ Yes

For Office Use Only

	Date Received

Underwriting Approval	Underwriting	Underwriting Date Stamp	Underwriting Comments

Applicant Name (First, Middle, Last)	Social Security Number	Group/Billing Unit No.	Effective Date

C. Health Questions

If you, or any person named in this application, ever has been affected by or treated for any of the conditions listed below, please put an "X" in the box under the columns marked "Yes" to the right of the condition described, if not, please put an "X" in the column marked "No" to the right of the condition described. You must furnish information about each condition listed or your application will be returned. Information describing these conditions in more detail is on the back of this application. **If you change your answer, you must initial the change.**

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
Abnormal Jaw Closure (TMJ)			Drug Addiction			High Blood Pressure			Skin Disorder		
Alcoholism/Alcohol Abuse			Ear, Throat, Tonsil Disorders			Infertility and/or Testing			Spinal Disorder		
Allergies			Eating Disorder			Joint Disorder			Stomach Disorder		
Arthritis or Rheumatism			Abnormal Cholesterol/triglyceride levels			Kidney Disorder			Stroke		
Asthma, Respiratory Problems			Emphysema			Learning or Behavior Disorder			Previous Surgeries		
Back Disorder			Epilepsy and/or Seizure			Liver Disorder			Thyroid or Goiter		
Bladder Disorder			Eye Disorders/Disease *			Loss of Limb(s)			Tuberculosis		
Blood Disease			Foot Disorders			Meningitis			Tumor(s), Cyst(s) or growth		
Bone Disease/Deformity			Fractures or Dislocations			Menstrual Problem			Ulcerative Colitis, or Crohn's		
Bowel Disorder			Gall Bladder Disorder			Mental, Nervous Condition			Ulcers (Stomach or Duodenum)		
Breast Disorder			Genital Herpes/Syphilis			Mental Retardation			Urinary Tract Disorder		
Cancer			Headaches or Migraine			Neurological Disease			Varicose Veins		
Chronic Chest/Lung Disorder			Hearing Impairment			Pap Smear, abnormal			Vein or Artery Disease		
Cirrhosis of the Liver			Heart Disease or Murmur			Paralysis			Other conditions		
Colitis, Spastic Colon, Polyps			Hepatitis			Prostate Disorder					
Congenital Disease/Defects			Hernia – Hiatal			Rectal Disorder					
Diabetes/Pancreatic Disorders			Hernia – Inguinal			Reproductive Organs Disorder					
Disfiguring Scars			Hernia – Umbilical			Sinus Disorder					

*Other than corrective lenses.

☐ Yes ☐ No Is anyone listed on this application currently pregnant? If "Yes," expected due date: _____/_____/_____

☐ Yes ☐ No Has anyone listed on this application ever been diagnosed with or treated for AIDS or AIDS Related Complex, or tested positive for HIV?

☐ Yes ☐ No Has future surgery, diagnostic testing, or medical treatment been recommended for any person listed on this application? If "Yes," explain: _____

☐ Yes ☐ No Has anyone had medical advice or treatment by a doctor, chiropractor, psychologist, or therapist or any health care professional within the last five years? If "Yes," explain: _____

☐ Yes ☐ No Has an insurance company refused or restricted health coverage on any person listed on this application? If "Yes," explain: _____

☐ Yes ☐ No Does any person listed presently take prescription or non-prescription medication? If "Yes," explain: _____

Health Statement **(If you checked "Yes" to any of the health questions on this form, please complete this section. Use additional pages if needed and include your signature and date.)**

Name of Person	Name of Condition Specify Right or Left if Applicable	Dates and Duration of Treatment	Type of Treatment and Degree of Recovery	Name and Address of Physician

D. Condition Rider/Coverage Denial

If the following member(s) of our family is (are): ☐ Offered a condition rider ☐ Offered a rate-up ☐ Denied coverage

Member's Name(s): _____

Please continue underwriting the remaining members of our family on this underwritten application.

Enclosed is a Secure Blue Select, Secure Blue, or Blue Care application for _____ should this occur.

Applicant Name (First, Middle, Last)	Social Security Number	Group/Billing Unit No.	Effective Date

E. Prior Coverage – Read the "Notice to Applicant Regarding Replacement of Accident and Sickness Insurance" on back of application.

Immediately prior to the effective date of this policy, did you or anyone named on this application have qualifying previous coverage(s) for 12 or more months without a lapse of more than 63 days? ☐ Yes ☐ No

If yes, what type of coverage was the qualifying previous coverage(s)?

☐ Employer Group ☐ COBRA ☐ Individual ☐ Short Term Major Medical

☐ Other (please identify) _____

If yes, who has this coverage and with which insurance company? _____

_____

If yes, will this policy replace the current coverage? ☐ Yes ☐ No

If yes, what is the termination date of the current coverage? _____

Name of Contract Holder of current coverage_____

If the current coverage is Blue Cross and Blue Shield (BCBS), what state were you enrolled in?_____BCBS ID Number _____

I ☐ want ☐ don't want continuous coverage from my previous BCBS plan.

Are you submitting an application for Short Term Major Medical coverage with this application? ☐ Yes

Please provide the name of your employer and your spouse's employer if listed on this application _____

F. Tobacco Declaration

☐ Yes ☐ No I, my spouse, or my dependents (if included on this application) have used tobacco during the 12 months immediately preceding the date of this application. If yes, please indicate name and relationship _____

_____

If you answered "No", you are eligible for a special tobacco non-user rate. If this status changes you must notify us immediately. We may require you to recertify this status in the future. If we determine within the initial 2 years that this status is incorrect we will retroactively collect historical differences in premiums before claims will be paid and we will start applying the tobacco user rate on the first of the month following our receipt of this information.

G. Life Insurance Information

1a. Which USAble Life Life Insurance Plan are **you** applying for?

Ten Year Term Insurance – Renewable, Convertible

☐ $10,000 ☐ $20,000 ☐ $ 40,000

☐ $60,000 ☐ $80,000 ☐ $100,000

1b. Which USAble Life Life Insurance Plan is your **spouse** applying for? (Only if applying for Health Coverage)

Ten Year Term Insurance – Renewable, Convertible

☐ $10,000 ☐ $20,000 ☐ $ 40,000

☐ $60,000 ☐ $80,000 ☐ $100,000

2. How do you want to pay your life insurance premiums?

☐ **Direct Bill.** If so, on what basis? ☐ Quarterly ☐ Semi-annually ☐ Annually

☐ **Automatic Account Withdrawal.** If so, on what basis? *(Include a voided check).*

☐ Monthly–4th of the month ☐ Quarterly ☐ Semi-annually ☐ Annually

From: ☐ Checking or ☐ Savings **If payor did not sign the application, pre-authorization form is needed. (M-5779)**

3a. Applicant's Beneficiary Designation

Primary Beneficiary _____

Relationship _____

Contingent Beneficiary _____

Relationship _____

3b. Spouse's Beneficiary Designation

Primary Beneficiary _____

Relationship _____

Contingent Beneficiary _____

Relationship _____

4. Will this life insurance replace any existing life insurance or annuities with this or any other company? **Applicant** ☐ Yes ☐ No **Agent** ☐ Yes ☐ No

5. Unless otherwise specified, the applicant will be the owner of the life insurance policy. Owner: _____

H. Agreement and Certification

I have read and understand the Agreement and Certification provision and the Notice to Applicant Regarding Replacement of Accident and Sickness Insurance both appearing on the back of this application and an Outline of Coverage for the health and dental coverage. I UNDERSTAND AND AGREE THAT THE HEALTH, DENTAL, AND LIFE COVERAGE APPLIED FOR WILL NOT BE EFFECTIVE UNTIL WELLMARK OR USABLE, AS THE UNDERWRITERS OF THE HEALTH, DENTAL, AND LIFE COVERAGES, RESPECTIVELY, HAVE REVIEWED AND APPROVED THIS APPLICATION AND NOTIFIED ME IN WRITING OF APPROVAL OF SUCH INSURER'S RESPECTIVE COVERAGE. **I understand and agree that Wellmark will continue the medical underwriting process up to the effective date of coverage I requested on the application or the effective date assigned by Wellmark. This means that if a condition arises that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment, or a condition arose for which medical advice, diagnosis, care or treatment was received or recommended prior to the effective date of coverage, regardless of the date I signed the application or the date the application was acted upon by Wellmark, I will so inform Wellmark by sending this information in writing to:**

Wellmark Blue Cross and Blue Shield of Iowa
636 Grand Avenue, Station 19
Des Moines, IA 50309

Applicant Signature X _____ Date ____/____/____

Spouse Signature X _____ Date ____/____/____

Agent Signature _____ Date ____/____/____

Agent Name _____ Agent No. | | | | | | | | | |

Any payment will be deposited immediately upon Wellmark's receipt of this application. Should my application not be approved, my payment will be refunded in full.

Descriptions of Conditions

Abnormal Jaw Closure Any problem with the jaw including temporal mandibular joint disease (TMJ).

Abnormal Cholesterol/Triglyceride levels An adnormally high or low cholesterol, triglyceride or any other component of a blood lipid test.

AIDS or AIDS Related Complex Acquired Immune Deficiency Syndrome or AIDS related complex (ARC).

Alcoholism, Alcohol Abuse Any treatment for alcohol abuse or counseling by AA or others.

Allergies Any treatment for allergies (other than drug allergies) by shots, medication or oral drops.

Arthritis or Rheumatism Rheumatoid, degenerative or osteoarthritis, bursitis or tendonitis.

Asthma, Respiratory Problems Treatment for asthma, including exercise induced asthma.

Back Disorder Any disorder of the back or spine including strains, injuries, abnormal curvature (scoliosis or kyphoscoliosis), intervertebral disc (slipped disc) or any chiropractic care.

Bladder Disorder Chronic or recurrent bladder infections, bladder stones, inability to control bladder, retention of urine.

Blood Disease Low blood count, abnormal bleeding from the skin; internal bleeding; leukemia; aplastic anemia; Hodgkin's Disease; hemophilia; or Sickle Cell Disease.

Bone Disease/Deformity Paget's Disease, exostosis, osteoporosis, bone tumors or deformity.

Bowel Disorder Ulcerative Colitis, polyps, Crohn's Disease, Regional Enteritis, bleeding from the bowel, irritable bowel, diverticulosis.

Breast Disorder Breast masses, fibrocystic breast disease. Include date of biopsy(s).

Cancer Any type of cancer including skin cancer and melanoma.

Chronic Chest/Lung Disorder Emphysema, Chronic Obstructive Pulmonary Disease (COPD), Chronic Bronchitis or any chronic lung condition.

Cirrhosis of the Liver Alcoholic cirrhosis or biliary cirrhosis.

Colitis, Spastic Colon, Polyps Any type of colitis, ulcerative colitis or irritable bowel syndrome or polyps.

Congenital Disease/Defects All birth defects such as cleft lip or palate, fused fingers or other defects.

Diabetes/Pancreatic Disorders Type I or II sugar diabetes controlled by oral medication, insulin or diet; acute or chronic pancreatitis, pancreatic cyst.

Disfiguring Scars Serious scars, such as burns of face or body, scars on the face from an accident or severe acne scars.

Drug Addiction Any treatment or counseling for any type of drug addiction.

Ear, Throat, Tonsil Disorders Treated deafness, tubes in ears, chronic ear infections, chronic sore throat, enlarged tonsils or adenoids, vocal cord nodules.

Eating Disorder, Anorexia, or Bulimia Any disorder characterized by gross disturbances in eating behavior.

Emphysema Any treatment for or diagnosis of emphysema or Chronic Obstructive Pulmonary Disease (COPD).

Epilepsy and/or Seizure Any history of seizures. Include date of last seizure.

Eye Disorders/Disease Retinal detachment, cataracts, macular degeneration, chronic eye infection, injury, loss of eye or eye prosthesis, other than visual acuity corrected by lenses.

Foot Disorders Any disorder or deformity of the foot including bunions, hammertoes, flat feet, bone spurs and any use of supports or special foot wear.

Fractures or Dislocations Any fracture or dislocation of a bone or joint.

Gall Bladder Disorder Treatment of gallstones, removal of gallstones or gall bladder, or gall bladder attack.

Genital Herpes/Syphilis Treatment for genital herpes, syphilis or any venereal disease.

Headaches Migraine, cluster headaches, or chronic tension headaches.

Hearing Impairment Any treatment for or use of hearing aid for hearing loss.

Heart Disease or Murmur Any disease of the heart that has been diagnosed or treated, such as heart attack, coronary artery disease, abnormal rhythm, birth defect, or infections, mitral valve prolapse.

Hepatitis Any treatment for acute or chronic hepatitis.

Hernia Inguinal, ventral, incisional, or hiatal hernia. Indicate type.

HIV Positive Having positive reactions on tests for the human immunodeficiency virus used to indicate that an individual has been infected with the HIV virus but does not yet have AIDS.

High Blood Pressure Any elevation of blood pressure, either presently being treated by medication or diet or treated in the past.

Infertility and/or Testing Problems with conception or fertilization.

Joint Disorder Treatment or surgery for any joint disorder including exploratory surgery or joint fusion.

Kidney Disorder Kidney stones, enlarged, misplaced, injured kidney, chronic infection or nephritis.

Learning or Behavior Disorder Such as hyperactivity or Attention Deficit disorder, any treatment or counseling for behavior disorder.

Liver Disorder Any liver disorder such as cirrhosis, jaundice, hepatitis.

Loss of Limb(s) Any loss of limb (legs, arm, fingers, toes) or use of prosthetic device.

Meningitis Diagnosis or treatment for viral or bacterial spinal meningitis.

Menstrual Problem Irregular periods, excessive bleeding, missed periods, miscarriages, endometriosis, hysterectomy, ovarian or fibroid cysts, pelvic inflammatory disease.

Mental, Nervous, Emotional Disorder Any disorder treated by a psychologist, physician or counselor such as schizophrenia, depression, anxiety, chemical imbalance, marriage counseling or family counseling.

Mental Retardation Diagnosis or treatment of mental retardation including Down's Syndrome.

Neurological Disease Any brain disorder such as abnormal growth in the brain (tumor), hydrocephaly (water on the brain); multiple sclerosis; amyotrophic lateral sclerosis (Lou Gehrig's Disease).

Pap Smear, Abnormal Diagnosis or treatment of abnormal pap; cervical dysplasia.

Paralysis Any loss of movement of a muscle or limb.

Prostate Disorder Infection or enlargement of prostate.

Rectal Disorder Bleeding, hemorrhoids, fissure, fistula, polyps, anal warts.

Reproductive Organs Disorder Any disorder of the female or male reproductive organs.

Sinus Disorder Any treatment for sinus problems or a disease leaving a nasal breathing problem.

Skin Disorder Diagnosis or treatment for any skin disease including acne, psoriasis, chronic contact dermatitis, and Systemic Lupus Erythematous.

Spinal Disorder Any condition of the spine such as curvature (scoliosis or kyphoscoliosis), intervertebral disc, fracture, dislocation needing medical treatment or chiropractic care.

Stomach Disorder Any disorder of the stomach or esophagus such as ulcer, stricture, gastritis, esophageal reflux, or hyperacidity.

Stroke Any treatment for, or history of a stroke.

Previous Surgeries Any condition needing surgery in the last five years or which will possibly need surgery in the future.

Thyroid or Goiter Enlargement of the thyroid, removal of nodule or lumps, hyperthyroidism (overactive), hypothyroidism (underactive), Graves' disease.

Tuberculosis Any history or treatment of tuberculosis.

Tumor(s), Cyst(s) or Growth Any type of lump, tumor, cyst or growth. (cancerous or benign)

Ulcerative Colitis, Crohn's or Regional Ileitis Diagnosis or treatment of ulcerative colitis.

Ulcers (Stomach or Duodenum) Any previous or present diagnosis and treatment of ulcer.

Urinary Tract Disorder Chronic or recurrent urinary tract infection, stricture of urinary tract, urethral stones or any condition of the urinary tract.

Varicose Veins History of vein stripping or varicose veins requiring medical treatment.

Vein or Artery Disease Any disease or accidental injury that has caused obstruction of a blood vessel to a body part; hardening of the arteries (arteriosclerosis); aneurysms; any blood clots of the lower extremities (superficial or deep vein thrombosis);blood clots that have traveled to the lung (pulmonary thrombosis).

Any Other Ailment or Disease If any disease, ailment or condition is present that has not been declared, it should be noted.

Agreement and Certification

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I understand that I am applying for coverage as indicated on the reverse side of this application which is underwritten by Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa providing the specified health care and dental coverages and USAble Life providing the life insurance (collectively, the "Insurers"). I further understand that coverage applied for will not start until after this application and the appropriate premium payment amount are received and accepted by each Insurer and an effective date of coverage is established by the Insurers. I also understand that I must pay to each Insurer the appropriate premium amounts in advance to maintain coverage.

I certify that, after this application was completed, I carefully and fully read it and that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication has been knowingly withheld. I understand that the Insurers will rely on the completeness and truthfulness given in the statements made in this application or by telephone or in writing to Wellmark as reflected in the Documentation of Information Received form (Form P-5340), and that if I have made any false statements or misrepresentations in this application or by telephone or in writing to Wellmark as reflected in Form P-5340, or have failed to disclose or have concealed any material fact, each Insurer will be entitled to declare coverage provided under this application void and to refuse allowance of benefits to any person thereunder.

I authorize any health care provider to release medical records to the Insurers when reasonably related to the coverage for which I have applied. If any law or regulation requires additional authorization for release of medical records, I will give this authorization. I further agree upon request to furnish the Insurers all information required to administer the requested coverage.

I have been informed of and understand that if my application is approved, all covered members will have a 365-day waiting period for pre-existing conditions unless any one of the members covered under the policy had qualifying previous coverage with no more than a 63-day lapse immediately prior to the effective date of this coverage.

In the event I have selected HSA coverage on this application, I understand that enrolling in HSA coverage does not guarantee that I am or will be eligible to make contributions to a health savings account or that contributions can be made to a health savings account on my behalf.

In the event I have selected Blue Dental coverage on this application, I certify that I have been informed that there will be a 6 month waiting period before benefits are available for basic restorative services including, but not limited to, fillings, extractions, and oral surgery, and a 12 month waiting period before benefits are available for major restorative services including, but not limited to, endodontics, periodontics, crowns, onlays, and inlays. I understand these dental coverage waiting periods will not be waived or reduced even if I have qualifying existing coverage or qualifying previous coverage.

I understand that any health condition amendments previously signed and in effect on current individual coverage issued by Wellmark will remain in effect under this new coverage if I am not required by Wellmark to answer health questions on this application.

I understand that I cannot be enrolled in any employer group health insurance plan issued by Wellmark on the effective date of this policy.

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

Your application states you intend to terminate your existing accident and sickness insurance and replace it with a policy or certificate to be issued by Wellmark Blue Cross and Blue Shield of Iowa (if approved). For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy or certificate if issued.

a. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy or certificate. This could result in denial or delay of a claim for benefits under the new policy or certificate, whereas a similar claim might have been payable under your present policy.

b. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your current policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

c. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical-health history. Failure to include all vital medical information on an application may provide a basis for Wellmark Blue Cross and Blue Shield of Iowa to deny any future claims and to refund your premium as though your policy or certificate had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.