Small Group Application

Wellmark BlueCross BlueShield of Iowa
Wellmark Health Plan of Iowa, Inc.

Independent Licensees of the Blue Cross and Blue Shield Association

BlueDental™

FORT DEARBORN LIFE
Insurance Company

N-5401 1/05

Failure to fill out this application completely may result in a delay of coverage.

Application for Health, Dental & Life Insurance

☐ NEW HIRE ☐ LATE ENROLLEE ☐ SPECIAL ENROLLEE ☐ CHANGE	Group/Billing Unit No.	Effective Date	Agent No.

A. Enrollment Information

Name (First, Last)	Social Security #	Soc. Sec. Disabled? ☐Yes ☐No	Medicare Enrolled? ☐Yes ☐No	☐ Male ☐ Female	Birthdate	Height	Weight

Address (Include Street, Building Name/No., Apt. No., City, State, Zip)	County	Telephone ( )	Marital Status ☐ Single ☐ Married ☐ Common Law (Notarized Affidavit Required)

Employer Name	Employer Address (Include Street, Building Name/No., Apt. No., City, State, Zip)	Occupation	Employment Status ☐ Full-Time ☐ Retiree ☐ Part-Time ☐ COBRA
		Health Coverage: HSA: ☐ Yes ☐ No	Hire Date:

B. Coverage Information: Please indicate which eligible coverage(s) you are choosing. Please check only one type of coverage per product.

Medical:	☐ Employee	☐ Employee/Spouse	☐ Employee/Child(ren)	☐ Employee/Spouse/Child(ren)
Dental:	☐ Employee	☐ Employee/Spouse	☐ Employee/Child(ren)	☐ Employee/Spouse/Child(ren)
Life: *	☐ Employee	☐ Employee/Spouse	☐ Employee/Child(ren)	☐ Employee/Spouse/Child(ren)
Disability: *	☐ Employee/Short Term	☐ Employee/Long Term		

Name (First, Last) List all persons to be covered excluding applicant.	Birthdate	Social Security Number	Gender	Height	Weight	Full-Time Student?	Soc. Sec. Disabled?	Medicare Enrolled?
Spouse			☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No
Dependent			☐ M ☐ F			☐ Yes	☐ Yes ☐ No	☐ Yes ☐ No
Dependent			☐ M ☐ F			☐ Yes	☐ Yes ☐ No	☐ Yes ☐ No
Dependent			☐ M ☐ F			☐ Yes	☐ Yes ☐ No	☐ Yes ☐ No
Dependent			☐ M ☐ F			☐ Yes	☐ Yes ☐ No	☐ Yes ☐ No
Dependent			☐ M ☐ F			☐ Yes	☐ Yes ☐ No	☐ Yes ☐ No

C. Medicare Coverage

Name of covered person: Medicare ID (HIC) No.: Effective Date (Part A): Effective Date (Part B):

D. Events Requiring Contract Changes: ☐ **Marriage** ☐ **Death** ☐ **Divorce** ☐ **Birth/Adoption** ☐ **Loss of Coverage** ☐ **Other, specify**_____

Name of Affected Party:	Date of Event:

E. Other Carrier Information:	**F. Prior Coverage Information:**
☐ Yes ☐ No Will you, your spouse or your dependents keep other health coverage in addition to this Wellmark, Inc. coverage? If yes, please complete the following section.	☐ Yes ☐ No New Hire: Did you, your spouse or dependents have health coverage within 63 days prior to the hire date stated above? ☐ Yes ☐ No Special Enrollee/Late Enrollee: Did you, your spouse or dependents have health coverage within 63 days prior to the effective date of this coverage? If yes, please complete the following section.
Name (First, Last)	Name of Covered Person(s):
Employer (if applicable)	Employer (if applicable)
Insurance Company/HMO Name and Address	Insurance Company/HMO Name and Address

Policy No.	Contract Type ☐ Single ☐ Family ☐ 2-Person	Effective Date	Policy No.	Contract Type ☐ Single ☐ Family ☐ 2-Person	Effective Date	End Date

G. Life/Disability Options (Please complete only if you checked life or disability above.)	**Date of Birth**	**Social Security #**	**Relationship**	**Benefit %**
☐ Primary Beneficiary				
☐ Primary Beneficiary ☐ Contingent Beneficiary (please indicate if beneficiary is Primary or Contingent)				

Employee Salary ☐ Weekly ☐ Monthly ☐ Annual $_____ Insurance Class:

*Underwritten by Fort Dearborn Life Insurance Company.

Social Security Number	Marketing Representative/Agent Initials:

H. Health Questions—Only Applies To New Groups Through First Year of Enrollment

The following health questions pertain to your health coverage only and will be used to assess your employer health coverage risk. If you, or any person named in this application, has been diagnosed or treated in the last **10 years** for any of the conditions listed below, **please put an "X" in the box, and explain in Section I below.**

☐ AIDS or a positive HIV test	☐ Drug or Alcohol Abuse	☐ Mental or Nervous Disorder
☐ Allergy/Asthma	☐ Ear, Nose & Throat Disorder	☐ Migraine Headaches
☐ Back or Neck Disorder	☐ Heart/Circulatory Disorder	☐ Nervous System/Brain Disorder
☐ Blood Disorder	☐ High Blood Pressure	☐ Respiratory/Lung Disorder
☐ Bone/Joint/Muscular Disorder	☐ High Cholesterol	☐ Skin Disorder
☐ Cancer	☐ Infertility/Reproductive Organ Disorder	☐ Stroke
☐ Diabetes/Pancreatic Disorder	☐ Kidney/Bladder/Urinary Disorder	☐ Tumor or Cyst
☐ Digestive/Intestinal Disorder	☐ Liver Disorder	☐ Current Pregnancy; due date _____/_____/_____

List any other condition, treated in the last 10 years, not mentioned above:

☐ Yes ☐ No In the last year, has anyone received medical treatment apart from routine physicals or inoculations? **(If yes, list in section below.)**

☐ Yes ☐ No Do you or any of your dependents take any medicine, drugs, pills or require shots? **(If yes, list in section below.)**

☐ Yes ☐ No Do you or any of your dependents have treatments, tests, hospitalization or surgery planned in the future? **(If yes, list in section below.)**

I. Health Statement (If you checked any of the health questions or listed any other conditions on this form, please complete this section. Use additional pages if needed and include your signature and date.)

Name of Person	Condition	Date Diagnosed	Dates Treated	Type of Treatment/ Names of Medications	Are Medications Ongoing?	Is Treatment Ongoing?

Office Use Only	

J. Waiver (Please complete if you are waiving health, dental, life or disability benefits.)

☐ I waive health coverage for me and all my dependents. Please indicate reason:
☐ I (We) have coverage under another health care benefit plan. ☐ I (We) do not wish to pay the employee contribution required for the health benefit plan.

☐ I waive dental coverage for me and all my dependents. Please indicate reason:
☐ I (We) have coverage under another dental plan. ☐ I (We) do not wish to enroll in the dental plan.

☐ I waive life coverage for me and all my dependents. ☐ I waive disability coverage

Note: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact Customer Service, Wellmark, Inc., P.O. Box 9232, Station 9, Des Moines, IA 50306-9232, or call 800-524-9242.

K. Authorization and Certification

I have read and understand the Authorization and Certification language on the back of this application and acknowledge receipt of a fully completed copy of this application.

Employee Signature_____ Date _____/_____/_____

Authorization 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 making application for the coverage sponsored by my employer or group sponsor offered by Wellmark, Inc., doing business as Wellmark Blue Cross Blue Shield of Iowa, or Wellmark Health Plan of Iowa, Inc. (each referenced herein as "Wellmark") and, when applicable, life and/or disability insurance provided by Fort Dearborn Life Insurance Company (collectively the "Plans"). I authorize my employer, as my agent, to deduct from my pay or collect from me in advance the monthly rates therefore and remit such sums to the Plans on my behalf. This authorization is to remain in effect until the Plans are notified by me or my employer to the contrary. I understand that written notice of rate changes will be furnished by my employer as my agent. I further understand that the coverages applied for will not start until after this application and the appropriate coverage rates are received and accepted by each Plan and an effective date of coverage is established by the Plans.

I certify that, after this application was completed, I carefully and fully read it, 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 Plans will rely on the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, the Plans will be entitled to declare the contracts applied for void and to refuse allowance on benefits to any person thereunder.

In the event I have selected Health Savings Account (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 an HSA or that contributions can be made to an HSA on my behalf.

If I am applying for life and/or disability insurance, I understand that if I am not actively at work on the effective date of my coverage, my life and/or disability insurance will not begin until the day I return to work. I further understand that if I have chosen to waive life and/or disability insurance and I wish to reapply at a later date, I will be required to furnish evidence of insurability satisfactory to the life insurance carrier selected by my employer or group sponsor.

I authorize any health care provider, including but not limited to; surgeon, physician, psychologist, nurse, social worker, or health care facility to release to the Plans all health & mental records, including those records protected by Federal or State law relating to AIDS or AIDS related complex, mental health and substance abuse, the past, present, or future treatments or conditions for myself or for my dependents eligible for health care coverage. This information is being used to carry out pre-enrollment underwriting and is in force until that process is complete, at which time it expires. I understand that I have the right to revoke this authorization in writing at any time by delivering such written notification to the requestor. I understand that a revocation is not effective until received by the requestor. I further understand that any revocation is not effective to the extent that the Plans or Provider have relied on it in the use or disclosure of protected health information.

This form does not authorize the redisclosure of medical information. Federal and State regulations do not allow further disclosure of mental health, substance abuse and AIDS/HIV related information. Wellmark maintains the confidentiality of **all** information received and it will not be released to any person or facility unless the individual is applying for life and/or disability coverage underwritten by Fort Dearborn Life Insurance Company in which case the application, without any further health records or Attending Physician Statements (APS) received, will be released to Fort Dearborn Life Insurance Company.

The protected health information described above may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

I understand that I have the right to refuse to sign this authorization, but that the Plans then have the right to condition eligibility determination and enrollment on the receipt of this signed authorization.