Wellmark Iowa

Wellmark Blue Cross and Blue Shield of Iowa is an independent licensee of the Blue Cross and Blue Shield Association.

Application for Employer Group Retiree Health Insurance

Mail to: Wellmark Blue Cross and Blue Shield of Iowa
PO Box 9232 - Mail Station 3W294
Des Moines, Iowa 50306-9232
Email: updatesgroupmembership@wellmark.com

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

Complete checked section if you are using this form to:	**A**	**B**	**C**	**D**	**E**	**G**
Newly enrolling medical program	✓	✓	✓	✓		✓
Change billing option	✓	✓		✓		✓
Cancel policy	✓	✓			✓	✓

Are you an existing member of this Employer Group Retiree Program? Wellmark ID Number_____

A. Employer Information (Completed by Employer)

Employer Name University of Northern Iowa Effective Date:_____/_____/_____

Employer Group Number_____ Subgroup_____

B. Retiree Information

Name (First, MI, Last)_____

Date of Birth _____/_____/_____ (mm/dd/yyyy) Gender Male ☐ Female ☐

Social Security Number _____ (Social Security Number (SSN) must be provided.)

Physical Address Line 1 (Street Address or Suite#)_____

Physical Address Line 2 (PO Box, Street Address)_____

City_____ State_____ ZIP_____

If mailing address is NOT the same as the physical address listed above, please complete the mailing address information.

Mailing Address Line 1 (Include Street, Bldg Name/No., Apt No.)_____

Mailing Address Line 2 (PO Box, Street Address)_____

City_____ State_____ ZIP_____

Preferred Phone Number (_____) _____

Email Address (optional)_____

C. Medicare Coverage (Required)

Please take out your Medicare ID card and use it to assist you in completing this section of the application.

Fill in the blank spaces so they match your red, white and blue Medicare ID card exactly.

If you have Medicare Part D, what is the effective date?

_____/_____/_____

Name/Nombre:

Medicare Number/Número de Medicare:

Entitled to/Con derecho a: Coverage starts/Cobertura empieza

HOSPITAL (Part A) _____/_____/_____

MEDICAL (Part B) _____/_____/_____

D. Choose the program for which you are applying

Check the program for which you are applying: ☐ Program F ☐ High Deductible Program F ☐ Program G ☐ Program N

Choose your method of payment

☐ **Yes** ☐ **No** **Will your employer be paying for this program?** (If yes, no other billing information is needed, skip this billing section)

☐ **Yes** ☐ **No** **I will be paying for this program.** (Must complete the following banking information or complete M-5779)

Billing Address (if applicable)

Payer's Name_____

Payer's Mailing Address (Include Street, Bldg. Name/No., Apt No.)_____

PO Box_____ City_____ State_____ ZIP_____

☐ D1. **Direct bill**. On what basis? ☐ Quarterly ☐ Semi-annually ☐ Annually
☐ D2. **Automatic** account withdrawal from applicant's account
☐ D3. **Automatic** account withdrawal from account other than applicant's

If you selected payment method D2. or D3., please complete the following:
On what basis? ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually
Date of withdrawal: ☐ First of the month ☐ Fifth of the month
From: ☐ Checking ☐ Savings

Complete the following information:

Financial Institution Name_____

Bank Account Name(s) (exactly as it appears on the account)_____

Financial Institution Routing Number (9 digits) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Bank Account Number_____

If direct bill is ***not*** selected:
As the bank account holder, I hereby authorize Wellmark to make automatic withdrawals from the account shown above in the amount of my periodic premium payment as it may be adjusted from time to time. If the undersigned is not the applicant, I understand and agree that notices of any premium adjustments when provided to the applicant shall constitute notice to the undersigned of any such adjustment. I hereby certify that I have read and understand the provisions of the Application Agreement and Certification section. This authorization shall supersede and replace any previous authorization given by me for automatic premium withdrawal.

The member will be responsible for any fee assessed by their bank for stop-payment orders that the member makes as well as the $25 fee assessed by Wellmark for a returned (not honored) payment and an additional $25 reinstatement fee if the policy terminates.

Authorized Signature of Bank Account Holder (if other than applicant)_____ Date_____/_____/_____

You may cancel automatic account withdrawal at any time. However, we need to receive your written notification at least 20 days before your next scheduled withdrawal.

E. Termination

☐ Terminate my policy

Date: _____/_____/_____ (Earliest termination date will be the end of the month in which the form is received)

F. Statements

1. You do not need more than one Medicare supplement policy or other policy providing coverage supplemental to Medicare.
2. If you purchase this policy (certificate), you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a policy supplemental to Medicare.
4. Counseling services may be available in your state to provide advice concerning your purchase of a policy supplemental to Medicare and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

G. Application Agreement and Certification

My signature verifies that, to the best of my knowledge and belief, I have completed this application accurately and completely. I understand that my coverage will not begin until Wellmark Blue Cross and Blue Shield of Iowa receives and accepts this application and assigns an effective date of coverage.

My signature also verifies that I authorize any health care provider to release medical records to Wellmark Blue Cross and Blue Shield of Iowa when reasonably related to the health insurance coverage for which I have applied. If any law or regulation requires additional authorization for release of medical records, I will give this authorization.

Consent to Contact Me Via Residential Telephone, Cellular Phone, Text and Email Messages

☐ By checking this box and entering my signature on this application, I hereby provide my consent to Wellmark to contact me about my Wellmark policy or products and services that may be available to me. Wellmark may provide this information to me using residential telephone, cellular telephone or wireless device, text message or email contact information provided to Wellmark from time to time. If I provide a telephone number for voice calls, I understand that Wellmark may contact me via live or prerecorded calls. I give Wellmark permission to use my personal data (including personally identifiable information) in accordance with Wellmark's privacy policy to determine the types of products and services that may be offered to me. I understand the telephone company or other communications carrier may impose charges for these contacts and that I am not required to give this consent to purchase any goods or service. I understand I may revoke this consent at any time by contacting Wellmark Customer Service.

Applicant Signature_____ Date_____/_____/_____

OR

Power of Attorney (POA) or Legal Guardian (if applicable):

NOTE: If POA or legal guardian, include a copy of the general POA granting such authority. Do not include a copy of the medical or durable POA.

POA or Legal Guardian Name (please print)_____

POA or Legal Guardian Signature X_____ Date _____/_____/_____