An Independent Licensee of the Blue Cross and Blue Shield Association

Application For Short Term Major Medical Expense Policy

1601 West Madison • Sioux Falls, SD 57104	FB Membership No. and FB County No., if applicable	Group/Billing Unit	County #

ELIGIBILITY CHECKLIST: If you answer "yes" to any of the following eligibility questions 1 through 5, a policy cannot be issued.

1. Is any person to be covered younger than 15 days old? ☐ No ☐ Yes
2. Will you, or any person to be covered, become eligible for Medicare or Medicaid during the policy term? ☐ No ☐ Yes
3. Within the last five years, have you or any person to be covered:
   a. been treated, diagnosed, or been advised to seek treatment for: heart or circulatory system disorder including hypertension, and high blood pressure; stroke; diabetes, cancer or tumor; alcohol abuse; drug abuse or chemical dependency? ☐ No ☐ Yes
   b. been treated, diagnosed or been advised to seek treatment for an immune system disorder including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or tested HIV positive? ☐ No ☐ Yes
   c. been declined for health insurance due to health reasons? ☐ No ☐ Yes
4. Are you, your spouse or any dependent now pregnant? ☐ No ☐ Yes
5. Do you or anyone else listed on this application currently have hospital and/or medical coverage through Wellmark Blue Cross and Blue Shield of South Dakota, or any other company, that will not terminate prior to the effective date? ☐ No ☐ Yes

Are you a resident of South Dakota? ☐ Yes ☐ No

MEMBERSHIP INFORMATION

NAME OF PRIMARY APPLICANT (FIRST, MIDDLE, LAST)	SOCIAL SECURITY NUMBER	BIRTHDATE
		/ /

ADDRESS (INCLUDE STREET, BUILDING NAME/NO., APT. NO., CITY, STATE, ZIP)	HOME PHONE	SEX	MARITAL STATUS
	( )	☐ M ☐ F	☐ SINGLE ☐ MARRIED

List all other individuals to be covered, in addition to primary applicant.

First MI Last	Relationship	BIRTHDATE M / D / Y	SOCIAL SECURITY NUMBER	SEX	FULL-TIME STUDENT
		/ /		☐ M ☐ F	☐ Yes
		/ /		☐ M ☐ F	☐ Yes
		/ /		☐ M ☐ F	☐ Yes
		/ /		☐ M ☐ F	☐ Yes
		/ /		☐ M ☐ F	☐ Yes

POLICY TYPE INFORMATION

THIS REQUEST FOR COVERAGE IS FOR:	POLICY MUST BE IN EFFECT FOR AT LEAST 30 DAYS AND CANNOT EXCEED 6 MONTHS	DEDUCTIBLE/OUT-OF-POCKET MAXIMUM
☐ SINGLE ☐ TWO-PERSON ☐ FAMILY	Effective Date* ______/______/______ Termination Date______/______/______	☐ $ 250 / $1,000 ☐ $ 500 / $1,500 ☐ $ 1,000 / $3,000

*The effective date cannot be prior to or the same date as the date you sign this application.
* Coverage ends at 12:01 AM on the termination date indicated.

PAYMENT INFORMATION

1. ☐ Yes ☐ No Will you be paying the premium through a business account? (if yes, answer a and b)
   a. If submitting a business check, are there any other employees besides you? (This includes full-time and part-time employees)
   ☐ Yes ☐ No (If yes, we cannot accept a business check for payment; a personal check must be submitted)
   b. Will your premium payments for this coverage be deducted on your federal income tax return other than the special health insurance deduction available to self-employed persons?
   ☐ Yes ☐ No (If yes, we cannot accept a business check for payment; a personal check must be submitted.)

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

PAYMENT INFORMATION, cont'd.

2. How do you want to pay for your health premiums and service fees? (Note: All billing periods are based on a calendar year.)

If paying by automatic withdrawal from checking, include a voided check.

- ☐ **a. Check enclosed for entire policy term.**
- ☐ **b. Monthly Automatic Account Withdrawal from Applicant's account.*** (available only for policy durations of 3 months or more)
- ☐ **c. Monthly Automatic Account Withdrawal from account other than Applicant's.*** (available only for policy durations of 3 months or more)

*Add $10.00 per month to the monthly premium amount, including the first month, if using this method. For monthly automatic bank payments, your policy must end on the first day of the month and cannot exceed 6 months of coverage.

If you checked b or c, please complete the following:

Date of withdrawal: ☐ 1st of the month ☐ 5th of the month

From: ☐ Checking (Attach voided check.)

☐ Savings (Please complete form M-3506.)

If you checked c:

As the Bank Account Holder, I hereby authorize Wellmark to make automatic withdrawals from the account shown on the attached voided check in the amount of my periodic premium payment and service fee, if applicable, as they may be adjusted from time to time. If the undersigned is not the Applicant, I understand and agree that notices of any premium and service fee 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 below. This authorization shall supersede and replace any previous authorization given by me for automatic premium withdrawal.

Bank Account Holder's Signature (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 scheduled withdrawal.

PREMIUM SUBMITTED $			☐ 1ST ISSUANCE ☐ 2ND ISSUANCE

APPLICATION AGREEMENT AND CERTIFICATION

I certify that I am legally authorized to apply for coverage for myself and for all other persons named in this application. I understand that I am making application for the coverage offered by Wellmark of South Dakota, Inc., doing business as Wellmark Blue Cross and Blue Shield of South Dakota (Wellmark), and that coverage will not start on the requested effective date until after this application and the premium submitted are received and accepted by Wellmark and the requested effective date is approved by Wellmark.

I certify that, after this application was completed, I carefully and fully read it, that the statement 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 Wellmark will rely upon 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 have concealed any material fact, Wellmark will be entitled to declare the health care policy void and to refuse allowance of benefits to any person thereunder.

I understand that the coverage applied for will not pay benefits for any expense incurred for any pre-existing condition. I understand that this is not a continuation of any previous coverage, including any prior Wellmark Blue Cross and Blue Shield of South Dakota Short Term Major Medical policy. I acknowledge that this plan may cause me to lose HIPAA portability rights (guarantees of eligibility for insurance in certain circumstances) in South Dakota.

I understand and agree that the amount of my periodic premium payment and service fee, if applicable, will change as provided in the policy being applied for and from time to time based on changes in my coverage, including but not limited to, the number of covered family members, members' ages, or other factors that require adjustments to the total premium and service fee, if applicable.

I further understand and agree that, if I have elected to authorize automatic premium withdrawals from a deposit account, the automatic withdrawal will change periodically to correspond with the applicable premium and service fee. My authorization for automatic premium withdrawals shall include authorization for automatic withdrawal of any changed amount unless I call or provide my bank with written notice not less than three (3) business days before a scheduled withdrawal to stop the payment. If I call my bank to stop payment, I may be required to provide a written request within fourteen (14) days after my call. I will be responsible for any fee assessed by my bank for stop-payment orders that I make.

I acknowledge receipt of a copy of this application, an Outline of Coverage, a benefits policy and a provider directory. I have read and understand the Outline of Coverage and each provision of the foregoing Application, including but not limited to, the section entitled "Application Agreement and Certification." I hereby confirm the authority of Wellmark to make automatic withdrawals from my deposit account as set forth above and that this authorization supersedes and replaces any previous authorization given by me with respect to such authority. Any payment will be deposited immediately upon Wellmark's receipt of this application.

APPLICANT SIGNATURE ____________________ DATE ______/______/______

AGENT SIGNATURE ____________________ DATE ______/______/______

PRINT AGENT NAME ____________________

☐☐☐☐☐☐☐☐

AGENT NO.