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

Application for Blue Dental℠ and Avesis Vision & Hearing

Use this form to apply for Blue Dental and/or Avesis Silver Vision and Hearing. These plans are exclusively available for Wellmark Medicare supplement members. The earliest effective date of these plans will be the first of the month following the signature date on this form. The form may also be used to terminate your Medicare supplement plan, your Blue Dental and/or Avesis Silver Vision & Hearing plans. If you terminate your Medicare supplement plan your Blue Dental and/or Silver Vision & Hearing plans will also terminate.

REQUESTED EFFECTIVE DATE _____/_____/_____

Instructions: Use a ballpoint pen to complete the form and follow the guidelines listed below:

GUIDELINES				
Complete checked sections if you are using this form to:	**A**	**B**	**C**	**E**
Add Blue Dental plan	✓	✓		✓
Add Silver Vision & Hearing plan	✓	✓		✓
Change Blue Dental plan	✓	✓		✓
Change Silver Vision & Hearing plan	✓	✓		✓
Remove Blue Dental plan	✓		✓	✓
Remove Silver Vision & Hearing plan	✓		✓	✓
Terminate Medicare supplement and optional benefits	✓		✓	✓

A. EXISTING POLICYHOLDER INFORMATION

Existing Policyholder Name (First, Middle, Last)	Wellmark ID	
Physical Address *(Include Street, Bldg Name/No., Apt/Suite#)*	Telephone Number	
City	State	ZIP

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

Address Line 1 *(Include Street, Bldg Name/No., Apt/Suite#, PO Box)*

Address Line 2 *(City, State, ZIP)*

B. OPTIONAL BENEFITS

Please select one **Blue Dental℠ plan**. For current MedicareBlue Supplement members, with an existing Blue Dental plan, if you do not complete this section of the application, you will remain enrolled on your current Blue Dental plan.

☐ Blue Dental℠ 75 ☐ Blue Dental℠ 100

To determine full or partial waiting periods for dental coverage, please complete the section below.
Have you had other dental coverage, without a lapse of more than 63 days, prior to the effective date of this application?

☐ Yes ☐ No

If yes[1]:
Insurance Company Name_____ Policy ID_____

START _____/_____/_____ END _____/_____/_____

[1]If yes is marked and you do not complete the rest of this section, the full dental waiting period will be applied.

B. OPTIONAL BENEFITS, cont'd

Please select one **Avesis Silver Vision & Hearing plan**. For current MedicareBlue Supplement members, with an existing Silver Vision & Hearing plan, if you do not complete this section of the application, you will remain enrolled on your current Silver Vision & Hearing plan.

☐ Silver Vision & Hearing 100 ☐ Silver Vision & Hearing 130

If you have other vision, hearing, or dental coverage currently in force, and you intend to replace that coverage with a Blue Dental plan or a Silver Vision & Hearing plan, please read the "Notice to Applicant Regarding Replacement of Accident and Sickness Insurance" in Section D.

Silver Vision & Hearing plans are administered by Avesis, an independent vision insurance company that does not provide Wellmark Blue Cross and Blue Shield products and services. Avesis Silver Vision & Hearing plans are underwritten by Fidelity Security Life Insurance Company®, Kansas City, Missouri. Silver Vision & Hearing plans include hearing discount savings plans provided by Amplifon. Amplifon is an independent company that does not provide Wellmark Blue Cross and Blue Shield products or services.

C. TERMINATION (if you terminate your Medicare supplement plan, it will terminate all benefits)

Termination date will be the first of the month following receipt of the request to terminate coverage.

☐ Terminate Blue Dental plan
☐ Terminate Silver Vision & Hearing plan
☐ Terminate both Blue Dental and Silver Vision & Hearing plans
☐ Terminate Medicare supplement plan and Blue Dental and/or Silver Vision & Hearing plan(s)

D. NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

If you currently have existing limited scope dental, hearing, or vision insurance, and you intend to lapse or otherwise terminate that existing coverage and replace it with Blue Dental and/or Avesis Vision coverage in this application, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions you may presently have may not be fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been paid under your current policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present 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.
3. If after due consideration you still wish to terminate your present policy and replace it with new coverage, be certain to read this application and truthfully and completely answer all questions on the application. Failure to include all material and accurate information, including medical information, may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain all information has been properly recorded.

E. AUTHORIZATION, CERTIFICATION AND SIGNATURE

My signature is considered valid whether I supplied it by telephone or on paper and has the same full force and effect as my written signature.

Dental Waiting Periods

In the event I am adding dental coverage, I certify that I have been informed that waiting periods apply. I understand this dental coverage waiting period may be waived or reduced if I have qualifying existing coverage or qualifying previous coverage.

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 services. I understand I may revoke this consent at any time by contacting Wellmark Customer Service.

E. AUTHORIZATION, CERTIFICATION AND SIGNATURE, cont'd

I understand that by selecting Blue Dental and/or Avesis Silver Vision & Hearing products, and submitting this form I am electing to purchase an additional insurance product(s). I authorize Wellmark to collect premium for these product(s) in addition to my Medicare supplement plan. If I am set up on auto pay, these additional premiums would be automatically withdrawn from my bank account that is currently on file and which Wellmark has previously received authorization to debit.

Applicant's Signature X _____ 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 _____/_____/_____

Agent Name (please print)_____ Agent Phone No. (_____) _____

Agent Signature_____ Date _____/_____/_____

Agent ID __ __ __ __ __ __ __ __ __ Farm Bureau Service Center Number_____

Applicant's Farm Bureau Membership Number (if applicable)_____

Wellmark must receive the completed application within 15 days of the Applicant's signature date.

Send completed form to:
Wellmark Blue Cross and Blue Shield of Iowa
Mail Station 3W190
PO Box 14527
Des Moines, IA 50309-3527

OR

Fax to: 515-376-9045

OR

Email to: updatesindividualmembership@wellmark.com