Individual Health Plan Contract Change Form
(For Grandfathered Plans and pre-ACA Non-Grandfathered Plans)

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

GUIDELINES

Complete checked section if you are using this form to:	A	B	C	D	E	F	G	I
Add an eligible individual or a newborn to current coverage Reinstate an eligible individual on current coverage	✓	✓		✓				✓
Change billing option	✓					✓		✓
Remove a member	✓	✓						✓
Remove a member and member moving to new policy	✓	✓	✓	✓		✓		✓
Remove the policyholder	✓	✓	✓	✓		✓		✓
Cancel entire policy	✓						✓	✓
Complete if removing an optional benefit	✓				✓			✓

A. EXISTING POLICYHOLDER INFORMATION

Existing Policyholder Name *(First, Middle, Last)*	Social Security Number/Tax Identification Number

Social Security Number (SSN) or Tax Identification Number (TIN) must be provided for you and every covered member for timely processing. Further review may be necessary if a SSN or TIN is not provided.

Farm Bureau Membership Number	Farm Bureau Service Center Number

Please check the box to the left of item(s) you are changing and provide complete information. (Supporting documentation is required for all Special Enrollment Events.)

B. MAINTAINING COVERAGE

Removing Policyholder

- ☐ Active military duty
- ☐ Death
- ☐ Obtained Medicare coverage
- ☐ Obtained employer group coverage
- ☐ Obtained Medicaid coverage

List date of event: ______/______/______

Removing Member:

- ☐ Active military duty service (Please provide a copy of military papers, indicating date of entry.)
- ☐ Completion of full-time schooling of a dependent child age 26 or older
- ☐ Death
- ☐ Dependent child reaches age 26 and is not a full-time student or permanently disabled
- ☐ Divorce/annulment/legal separation
- ☐ Marriage of a dependent child age 26 or older
- ☐ Spouse obtains employer group coverage
- ☐ Other, Specify: ______________________________

List date of event: ______/______/______ **List name(s) of member(s) removed:** ______________________________

If removing a member without an event, your cancellation date will be the last day of the month following your signature date on this change form.

Cancellation date will be as applicable:

- Date of death for the policyholder or through the end of the month if family policy
- Date your Medicare coverage becomes effective
- Date you begin basic training or are called to active military service
- First of the month following start of employer group coverage (or last day of the month prior to employer group coverage)
- Last day of the month prior to Medicaid coverage

Adding Eligible Member to Existing Policy

- ☐ Adoption/foster care
- ☐ Birth
- ☐ Court ordered coverage
- ☐ Legal guardianship
- ☐ Marriage, including common law
- ☐ Previously enrolled dependent loses coverage

List date of event: ______/______/______

Wellmark Blue Cross and Blue Shield of Iowa and Wellmark Health Plan of Iowa, Inc. are independent licensees of the Blue Cross and Blue Shield Association.

C. POLICYHOLDER INFORMATION - (If converting an existing policy to a different policyholder)

Policyholder Name *(First, Middle, Last)*	Social Security Number/Tax Identification Number[1]
Physical Address (include Street, PO Box, Bldg. Name/No., Apt No., City, State, ZIP)	
Provide name of county in which policyholder resides:	
Mailing Address (include Street, PO Box, Bldg. Name/No., Apt No., City, State, ZIP)	
Telephone Number ( )	Email Address:
Farm Bureau Membership Number	Farm Bureau Service Center Number

D. MEMBERS ADDED TO EXISTING CONTRACT OR MEMBERS MOVED TO CONVERTED CONTRACT

Name (First, MI, Last)	Relationship	Date of Birth	Social Security Number / Tax Identification Number[1]	Gender	Full-time Student[2]	Disabled[2]	Tobacco User[3]
Applicant	Self			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Spouse	Spouse			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent 1				☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent 2				☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If you are adding a spouse/dependent to a Blue Advantage plan, you must select a personal doctor below.

☐ Yes ☐ No Are you, your spouse, or any dependents listed above enrolled in Medicare?

If yes, please provide names: ______________________________

[1]The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Failure to provide the SSN/TIN information may result in a monetary penalty, per violation, assessed to you by the IRS.

[2]Disabled dependents and full-time students age 26 or older must be unmarried to be eligible for coverage as a dependent.

[3]Answer yes if the person listed has used any form of tobacco during the 12 months immediately preceding the date of this application.

Personal Doctor: Please choose a Personal Doctor for each member of your family. This information is required for applicants choosing an HMO (Wellmark Health Plan of Iowa, Inc.) plan, including family members who live outside the network area (for example, those who are under age 26 and remain on a parent's policy). The personal doctor you choose must participate in the network associated with your plan. In addition, female members may choose an OB/GYN. You can access the Wellmark provider directory at Wellmark.com/finder or by calling 800-978-3221. You may also see a Personal Doctor referred to as a Primary Care Provider (PCP) in other Wellmark documentation. (If you need to provide information for more than four dependents, please provide that information on a separate sheet of paper and attach to this application.)

For each person named in Section A and D, complete the following information:

Applicant

Doctor Name: ______________________________

Doctor Address Line 1 (Street Address or Apt/Suite#): ______________________________

Doctor Address Line 2 (PO Box, Street Address): ______________________________

City: ______________________________ State: __________ ZIP: __________

☐ Yes ☐ No Are you an established patient?

OB/GYN Name (optional): ______________________________

OB/GYN Address Line 1 (Street Address or Apt/Suite#): ______________________________

OB/GYN Address Line 2 (PO Box, Street Address): ______________________________

City: ______________________________ State: __________ ZIP: __________

☐ Yes ☐ No Are you an established patient?

D. MEMBERS ADDED TO EXISTING CONTRACT OR MEMBERS MOVED TO NEW CONTRACT (CONT'D)

Personal Doctor, cont'd: Please choose a Personal Doctor for each member of your family. This information is required for applicants choosing an HMO (Wellmark Health Plan of Iowa, Inc.) plan, including family members who live outside the network area (for example, those who are under age 26 and remain on a parent's policy). The personal doctor you choose must participate in the network associated with your plan. In addition, female members may choose an OB/GYN. You can access the Wellmark provider directory at Wellmark.com/finder or by calling 800-978-3221. You may also see a Personal Doctor referred to as a Primary Care Provider (PCP) in other Wellmark documentation. (If you need to provide information for more than four dependents, please provide that information on a separate sheet of paper and attach to this application.)

For each person named in Section A and D, complete the following information:

Spouse

Doctor Name:____________________

Doctor Address Line 1 (Street Address or Apt/Suite#):____________________

Doctor Address Line 2 (PO Box, Street Address):____________________

City:____________________ State:__________ ZIP:__________

☐ Yes ☐ No Are you an established patient?

OB/GYN Name (optional):____________________

OB/GYN Address Line 1 (Street Address or Apt/Suite#):____________________

OB/GYN Address Line 2 (PO Box, Street Address):____________________

City:____________________ State:__________ ZIP:__________

☐ Yes ☐ No Are you an established patient?

Dependent 1

Doctor Name:____________________

Doctor Address Line 1 (Street Address or Apt/Suite#):____________________

Doctor Address Line 2 (PO Box, Street Address):____________________

City:____________________ State:__________ ZIP:__________

☐ Yes ☐ No Are you an established patient?

OB/GYN Name (optional):____________________

OB/GYN Address Line 1 (Street Address or Apt/Suite#):____________________

OB/GYN Address Line 2 (PO Box, Street Address):____________________

City:____________________ State:__________ ZIP:__________

☐ Yes ☐ No Are you an established patient?

Dependent 2

Doctor Name:____________________

Doctor Address Line 1 (Street Address or Apt/Suite#):____________________

Doctor Address Line 2 (PO Box, Street Address):____________________

City:____________________ State:__________ ZIP:__________

☐ Yes ☐ No Are you an established patient?

OB/GYN Name (optional):____________________

OB/GYN Address Line 1 (Street Address or Apt/Suite#):____________________

OB/GYN Address Line 2 (PO Box, Street Address):____________________

City:____________________ State:__________ ZIP:__________

☐ Yes ☐ No Are you an established patient?

E. REMOVAL OF OPTIONAL BENEFITS

To remove an optional benefit, please check the box to the left of the optional benefit you would like to remove.

☐ **Blue Dental**

☐ **Contraceptives** *(Available with grandfathered plans only. Contraceptive coverage included with non-grandfathered plans. Not applicable for Farm Bureau plans.)*

F. BILLING INFORMATION - Complete if converted policyholder or changing billing option.

1. ☐ Yes ☐ No Will your employer be paying any part of the premium or fee for this policy?

If "Yes":

1a. ☐ Yes ☐ No Are you a sole proprietor purchasing coverage only for yourself, yourself and spouse/dependents, and not purchasing coverage for any common law employee?

1b. ☐ Yes ☐ No Is your premium being paid by your employer through after-tax wage adjustments or payroll deductions?

Note: If you answered "yes" to number 1 and "no" to both 1a and 1b – State and federal law prohibits an employer from contributing to the payment of an employee's premiums for this plan unless the applicant is the sole proprietor or owner of a sole proprietorship or the premium is being paid by the employer after tax wage adjustment or payroll deduction. Therefore, you are not eligible to have premiums withdrawn from an employer's account.

2. How do you want to pay for health premiums? **Please do not send payment with this form.**

Note: All billing periods are based on a calendar year.

a. ☐ **Direct Bill.** On what basis? ☐ Semi-annually ☐ Annually

If you checked a, provide the billing address if different than the policyholder's mailing address.

Billing street address (include Street, PO Box, Bldg. Name/No., Apt No., City, State, ZIP)

____

b. ☐ **Automatic Account Withdrawal from Policyholder's account.**

c. ☐ **Automatic Account Withdrawal from account other than Policyholder's.**

If you checked b or c, 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:

I hereby certify that I have read and understand the section below entitled "Authorization and Certification," and agree to the terms regarding automatic premium withdrawals as described therein. As the bank account holder, I authorize Wellmark to make automatic withdrawals from the account shown in the amount of the premium and fees. I understand and agree that notices of any premium and fee adjustments provided to the policyholder shall constitute notice to the undersigned of any such adjustment. This authorization supersedes and replaces any previous authorization given by me for automatic premium withdrawal.

Bank Account Holder's Signature (if other than Policyholder): ____________________ **Date:** _____/_____/_____

You may cancel automatic account withdrawal at any time. However, we need to receive your written notification by the 10th of the month before your next scheduled withdrawal.

G. CANCELLATION OF ENTIRE POLICY

I am requesting cancellation of my entire policy effective _____/_____ /_______ (last day of the month). I understand Wellmark does not allow cancellation on odd dates, and the earliest available cancellation date is the last day of the month after Wellmark's receipt of this request. My coverage will continue through the last day of the month in which I notify Wellmark to cancel. If I have vision and/or dental benefits for any member under age 19 included in my health coverage, these vision and/or dental benefits will be canceled with my health coverage. To cancel automatic account withdrawal, Wellmark must receive this request by the 10th of the month prior to my next scheduled withdrawal. To otherwise stop payment, I will notify my bank. I will be responsible for any associated fees from my bank.

H. EFFECTIVE DATES

The coverage effective dates will be assigned according to Wellmark guidelines. For special enrollment events, Wellmark must be notified within 60 days of the event. The coverage effective date for special enrollment events will be the first of the month following the event. Exceptions are birth, adoption, placement for adoption, legal guardianship, court-ordered coverage, and foster child placement, or as otherwise required or permitted under federal or state law. For those events, coverage effective date is the date of the event.

I. AUTHORIZATION, CERTIFICATION AND SIGNATURE

I certify that I have carefully and fully read the Authorization and Certification language appearing below.

I certify that I am legally authorized to make changes in coverage for myself and on behalf of all other persons named on my current policy and in this form, and I further have confirmed with all persons named on my current policy and on this form that my signature is binding to change coverage. I further understand that coverage applied for will not start until this form and the appropriate premium and service fee payment amount, if applicable, are received and accepted by Wellmark.

If I am electing Health Plan Options offered by Wellmark Health Plan of Iowa, Inc., I understand that as a condition of eligibility for benefits under the coverage specified in this form, each person to be covered on one of these Health Plan Options must maintain his/her residency in an Iowa county. Failure to maintain such residency by any person named in this application will give Wellmark Health Plan of Iowa, Inc. the right to terminate the coverage specified in this application for that person not maintaining residency by giving that person not less than thirty (30) days notice in advance of termination of coverage and benefits will be denied unless the medical services are related to emergency services or an accidental injury.

The statements and answers set forth in this form are full, true, and correct. I have consulted with each other person named in this form to confirm that information about him/her is full, true, and correct. I understand that Wellmark will rely on the completeness and truthfulness of the information given in the statements made in this form or by telephone or in writing to Wellmark, and that, if I performed an act, practice, or omission that constitutes fraud or I have made an intentional misrepresentation of material fact in this form, Wellmark will be entitled to declare coverage applied for void and to refuse allowance of benefits to any person thereunder.

Special Enrollment Notification Period
For special enrollment events, Wellmark must be notified within 60 days of the event. Please see Section H for effective date information.

Tobacco User Status
If I answered “No” to the tobacco user question for any person listed in Section D, that person is eligible for a special tobacco non-user rate. If this status changes, I must notify Wellmark immediately. Wellmark may require me to recertify this status in the future. If Wellmark determines within the initial two years that this status is incorrect, Wellmark will retroactively collect historical differences in premiums before claims will be paid, and will start applying the tobacco user rate on the first of the month following Wellmark’s receipt of this information.

Dental Exclusion Periods
In the event I am adding a member to Blue Dental coverage which is underwritten by Wellmark, Inc. doing business as Wellmark Blue Cross and Blue Shield of Iowa, I certify that I have been informed that there will be a six-month exclusion period before benefits are available for basic restorative services including, but not limited to, fillings, extractions, and oral surgery, and a 12-month exclusion 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 exclusion periods will not be waived or reduced even if I or any other person named in this form have qualifying existing coverage or qualifying previous coverage.

Eligibility
If I become enrolled in Medicare during the term of this benefits policy, I understand that this benefits policy will provide benefits secondary to Medicare unless application of federal law determines this benefit policy must provide benefits primary to Medicare.

Providing Social Security Numbers or Tax Identification Numbers
In order for Wellmark to report my coverage status to the federal government, I understand I must provide to Wellmark my Social Security number or tax identification number and the Social Security numbers or tax identification numbers of all members covered under my coverage. The IRS requires that Wellmark report this information using the Social Security number or tax identification number of the plan member and each dependent. If Wellmark does not have Social Security or tax identification numbers, I understand that Wellmark will be unable to report and send the information needed to complete federal tax returns. If I have not previously provided the Social Security numbers or tax identification numbers to Wellmark for all members covered under my coverage, I will contact Wellmark by calling the Customer Service number on my ID card. I understand if I do not provide the Social Security numbers or taxpayer identification numbers to Wellmark for this purpose, I may be subject to a monetary penalty per violation imposed by the Internal Revenue Service.

Health Care Reform Mandates
If I currently have a grandfathered health plan, I understand that making a change to my current benefits could potentially change the grandfathered status of my health care plan. If I lose the grandfathered status of my health care plan, I may be required to move to an ACA health plan. If I currently have a pre-ACA non-grandfathered plan, I understand that making a change to my current benefits may require I move to an ACA health plan.

Payment Arrangements
I understand and agree that the amount of my periodic premium payment and 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, changes in benefits, payment obligations (such as deductible, coinsurance and copayments), the number of covered family members, members’ ages, changes in tobacco user status, or other factors that require adjustments to the total premium and fee, if applicable. These changes may occur at times other than at annual or other policy renewal.

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 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. AUTHORIZATION, CERTIFICATION AND SIGNATURE (CONT'D)

Coverage Renewability

I understand that coverage is automatically renewed by payment of my premium and applicable fees in advance; that a grace period of 31 days will be granted for the payment of each premium and fee due after the first premium and fees; and that, during this grace period, my policy will continue in force.

I understand that Wellmark may terminate my policy if:

- I fail to pay my premium and service fee when due; or
- I fraudulently use my policy or make an intentional misrepresentation of a material fact under the terms of my policy; or
- I become ineligible for coverage under this policy; or
- Wellmark decides to terminate coverage of similar policies by giving written notice prior to termination. In the event Wellmark terminates individual policies of the same coverage, I will be allowed to transfer to the offered replacement policy.
- I change my residence from the geographic service area served by Wellmark Health Plan of Iowa, Inc. if I am enrolling in a health plan option offered by Wellmark Health Plan of Iowa, Inc.

Wellmark.com

Important information is available to you at *Wellmark.com/Inform* that addresses a number of topics such as Wellmark's guidelines on investigational and experimental procedures, the methodologies Wellmark uses to compensate providers, and information on how to access Wellmark's internal claims appeal and external review process. You can also obtain this information by calling Wellmark Customer Service at 800-978-3221.

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 Wellmark 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.

ACKNOWLEDGEMENT

I have read and understand the Authorization and Certification language and hereby confirm the authority of Wellmark to make automatic withdrawals from my deposit account as described therein. This authorization supersedes and replaces any previous authorizations given by me for automatic premium withdrawal.

If a Wellmark Health Plan of Iowa, Inc. plan option was selected the applicant is a resident of Iowa.

Existing Policyholder Signature X ____________________ Date ____/____/____

Converted Policyholder Signature X ____________________ Date ____/____/____

If applicant is a minor, please sign below.

Parent/Legal Guardian Printed Name ____________________

Parent/Legal Guardian Signature X____________________ Date ____/____/____

If child(ren) only policy, list parent's (s')/legal guardian's (s') name(s) ____________________

Agent Signature, if applicable X____________________ Agent No. __ __ __ __ __ __ __ __

All pages of the completed contract change form must be received within 15 days of the signature date.

Send completed form to:
Wellmark Blue Cross and Blue Shield of Iowa
Mail Station 3W190
PO Box 14527
Des Moines, IA 50306-3527
OR
Fax to: 515-376-9045
OR
E-mail to: updatesindividualmembership@wellmark.com