Wellmark South Dakota

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

Application for MedicareBlue Supplement℠

Requested Effective Date
_____/_____/_____

A. Tell us about yourself.

Applicant Name *(First, Middle, Last)*		
Date of Birth *(mm/dd/yyyy)* _____/_____/_____	Gender ☐ Male ☐ Female	Social Security Number
Daytime Phone ( )	Email Address *(optional)*	

Address Information:

Physical Address *(Include Street, Bldg Name/No., Apt. No.)*	County Name	
City	State	ZIP

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

Mailing Address Line 1 *(Include Street, Bldg Name/No., Apt. No.)*		
Mailing Address Line 2 *(PO Box)*		
City	State	ZIP

B. Tell us about your tobacco usage.

☐ Yes ☐ No **B1.** Have you used tobacco during the 12 months immediately preceding the effective date of this application?

C. Provide us with your Medicare information.

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.

You must be enrolled in both Medicare Part A and Medicare Part B to be eligible for enrollment in a MedicareBlue Supplement policy.

Name/Nombre: _____

Medicare Number/Número de Medicare:

_____

Entitled to/Con derecho a:	Coverage starts/Cobertura empieza
HOSPITAL (Part A)	_____/_____/_____
MEDICAL (Part B)	_____/_____/_____

C. Provide us with your Medicare information, cont'd.

☐ Yes ☐ No **C1.** Did you turn age 65 in the last six months?

☐ Yes ☐ No **C2.** Did you enroll in Medicare Part B in the last six months?

If yes, what is your Part B effective date (*mm/dd/yyyy*)? _____/_____/_____

☐ Yes ☐ No **C3.** Are you applying for a plan effective date within six months after:

- your Medicare Part B effective date?

OR

- the first day of the month in which you turn age 65 (or the first day of the month prior to the month in which you turn 65 if your birth date is the first day of the month) **and** are currently enrolled in Medicare Part B?

STOP

If you answered **YES** to question C3 above, you are within your Medicare Supplement Open Enrollment Period and your acceptance is guaranteed. You do **not** have to answer health questions and can proceed to Section G of the application to select your plan. To determine your monthly premium amount, refer to the MedicareBlue Supplement - Preferred premium table in the Outline of Coverage.

If you answered **NO** to question C3 above, please continue to Section D to determine if your acceptance is guaranteed.

D. Review the following loss of coverage situations to determine if your acceptance is guaranteed.

If your previous coverage terminated more than 63 days prior to the date of this application, you are outside of your guaranteed issue rights period. You must complete the entire application including answering the health questions. Please go to Section E to determine the plan(s) for which you are eligible.

If you lost or are losing other health insurance coverage and received a notice from your previous insurer and/or employer saying that you are eligible for guaranteed issue of Medicare supplement insurance policy, or that you have certain rights to buy such a policy, you may be a guaranteed acceptance in one or more of our MedicareBlue Supplement plans.

If one of these situations applies to you, check the appropriate box at the left and then provide the date your coverage was effective and/or the date your coverage will end *(mm/dd/yyyy)*. **Check one only.**

If no selection is made in Section D, Wellmark will process this application as if these loss of coverage situations do not apply to you.

☐ Applies to me **D1.** I am enrolled in a Medicare Advantage plan, and my plan is leaving Medicare or will no longer be providing coverage in my area, or I have moved out of my plan's service area.

If applicable, please provide the date coverage will end _____/_____/_____

D. Review the following loss of coverage situations to determine if your acceptance is guaranteed, cont'd.

☐ Applies to me **D2.** I have Original Medicare and an employer group health plan and that plan is ending.

If this applies to you, check the option that describes your situation below:

☐ a. My employer will no longer be offering retiree health coverage
☐ b. I chose to disenroll from my employer retiree coverage
☐ c. My active employer group coverage is ending for any reason (including COBRA or Continuation coverage)
☐ d. After 30 months of coverage for end stage renal disease

If applicable, please provide the date coverage will end _____/_____/_____

☐ Applies to me **D3.** I have Original Medicare and a Medicare Select policy or a Medicare Cost plan and I am moving out of my policy's service area.

If applicable, please provide the date coverage will end _____/_____/_____

☐ Applies to me **D4.** I joined a Medicare Advantage plan or Programs for All-Inclusive Care for the Elderly (PACE) when I was first eligible for Medicare Part A or B, and within the first year of joining, I want to disenroll (Trial Right).

If applicable, please provide the date coverage was effective _____/_____/_____; and the date coverage will end _____/_____/_____

☐ Applies to me **D5.** I canceled my Medicare supplement policy to join a Medicare Advantage plan (or to switch to a Medicare Select policy) for the first time, have been in the plan less than one year, and want to re-enroll in my original Medicare supplement policy or my original Medicare supplement policy is no longer available (Trial Right).

If applicable, please provide the date coverage was effective _____/_____/_____; and the date coverage will end _____/_____/_____

☐ Applies to me **D6.** I have a Medicare supplement, a Medicare Advantage plan or a Medicare cost plan and I am losing my coverage because the insurance company went bankrupt, or my coverage is ending through no fault of my own.

If applicable, please provide the date coverage will end _____/_____/_____

☐ Applies to me **D7.** I am leaving a Medicare Advantage plan, a Medicare Cost plan or a Medicare supplement policy because I have been notified the insurance company has violated a provision of its contract with me or it misled me.

If applicable, please provide the date coverage will end _____/_____/_____

☐ Applies to me **D8.** No situations apply to me.

STOP

If you checked any of the D1-D7 situations above **and** your coverage did not end more than 63 days before the date of this application, your acceptance may be guaranteed. You do **not** have to answer health questions and can proceed to Section G of the application to select your plan. To determine your monthly premium amount, refer to the MedicareBlue Supplement - Preferred premium tables in the Outline of Coverage.

If none of the situations above apply to you, you must complete the entire application including answering the health questions. Please continue to Section E to determine the plan(s) for which you are eligible.

E. Answer the following health questions to determine the plan(s) for which you are eligible.

☐ Yes ☐ No **E1.** Do any of the following situations apply to you?

- Currently in the hospital or have been an inpatient within the last 90 days (excluding outpatient or overnight/observation beds)
- Receive or require dialysis
- Require bottled oxygen or an oxygen concentrator to help you breathe (this does not include the use of a CPAP machine for sleep apnea)

☐ Yes ☐ No **E2.** In the last two years, have you received medical advice, or testing **in preparation for** any of the following surgical procedures? (If the actual surgical procedure has already been completed, you may respond 'no' to this question.)

- Heart or bypass surgery (this includes having a pacemaker or defibrillator implanted, but not updates to an existing pacemaker such as replacement of the battery)
- Angioplasty or vascular surgery
- Back or spine surgery
- Joint replacement
- Surgery for any form of cancer
- Surgery to remove any type of tumor
- Amputation due to disease
- Organ transplant

☐ Yes ☐ No **E3.** In the last two years, have you received medical advice, treatment, or prescription medications from a health care professional for any of the following conditions?

- Liver problems related to cirrhosis, or hepatitis B or C
- Any form of cancer including leukemia, lymphoma, or melanoma (except basal cell and squamous cell skin cancer)
- Stroke or transient ischemic attack (TIA)
- Amyotrophic lateral sclerosis (ALS)
- Multiple sclerosis (MS)
- Acquired immune deficiency syndrome (AIDS) or tested positive for HIV
- Kidney or renal disease related to chronic renal failure
- Paraplegia or quadriplegia

STOP

If you answered **YES** to **any** of the questions in Section E above, you are only eligible for Plan A at the **standard** premium. To determine your monthly premium amount, refer to the MedicareBlue Supplement Standard premium tables in the Outline of Coverage. Please go to Section G and select Plan A.

If you answered **NO** to **all** of the questions in Section E above, please proceed to Section F to determine if you qualify for preferred premiums.

F. Review the list of health conditions and answer the following health question to determine if you qualify for preferred premiums.

Circulatory conditions
- Aneurysm
- Artery blockage
- Atrial fibrillation or flutter
- Cardiomyopathy
- Carotid artery disease
- Congestive heart failure
- Coronary artery disease
- Heart attack
- Peripheral artery disease
- Ventricular tachycardia
- Deep vein thrombosis or blood clot(s) in vein
- Hemophilia

Metabolic conditions
- Diabetes with one or more complications (such as: neuropathy/ nerve damage, kidney disease, or retinopathy)
- Diabetes requiring an insulin pump

Substance abuse
- Alcohol abuse or alcoholism
- Drug abuse or use of illegal drugs

Respiratory conditions
- Chronic obstructive pulmonary disease (COPD)
- Emphysema
- Chronic bronchitis
- Chronic asthma
- Chronic interstitial lung disease
- Chronic pulmonary fibrosis
- Cystic fibrosis
- Sarcoidosis
- Bronchiectasis

Kidney Conditions
- Polycystic kidney disease
- Renal artery stenosis
- Chronic renal insufficiency

Gastrointestinal conditions
- Chronic pancreatitis
- Esophageal varices

Musculoskeletal conditions
- Amputation due to disease
- Rheumatoid arthritis (RA)
- Spinal stenosis
- Osteoporosis with fracture

Organ transplant
- Organ transplant
- Bone marrow transplant

Auto-immune disorders or connective tissue disorders
- Scleroderma
- Systemic lupus erythematosus (SLE)

Psychological or mental disorders
- Bipolar or manic depressive
- Major depressive disorder
- Schizophrenia
- Anorexia nervosa

Eye condition
- Retinopathy

Neurological or nervous system conditions
- Hemiplegia (paralyzed on one side)
- Alzheimer's disease, dementia or Cognitive disorders
- Parkinson's disease
- Myasthenia gravis
- Seizure disorders

☐ Yes ☐ No **F1.** In the last two years, have you been diagnosed, treated, or been prescribed medication by a health care professional for any of the conditions listed above? You must also respond 'yes' to this question if you are currently receiving treatment and/or taking a medication to treat any of the conditions listed. (If you are uncertain as to whether a listed condition applies to you, please consult with your physician as to your specific diagnosis.)

STOP

If you answered **YES** to question F1 above, you qualify for the **standard** premium. To determine your monthly premium amount, refer to the MedicareBlue Supplement Standard premium tables in the Outline of Coverage. Please proceed to Section G and select your plan.

If you answered **NO** to question F1 above, you qualify for the **preferred** premium. To determine your monthly premium amount, refer to the MedicareBlue Supplement Preferred premium tables in the Outline of Coverage. You are also eligible for Plan A at **standard** premium. Please proceed to Section G and select your plan.

G. Choose the plan for which you are applying.

1. Check the MedicareBlue Supplement plan for which you are applying:
   a. ☐ Plan A ☐ Plan D ☐ Plan F[1] ☐ Plan G ☐ High Deductible Plan G ☐ Plan N

   b. If you elected Plan G or High Deductible Plan G, you may be eligible for a discounted premium based on your answer to the following question:

   Do you currently have a person living at your residence (but no more than three persons age 60 or older) who is:
   i. Your legal spouse; or
   ii. A person 18 years of age or older with whom you have continuously resided for the last 12 months
   ☐ Yes ☐ No

   If yes[2]:
   Name_____ Date of Birth_____/_____/_____

   Select only one (Relationship)**:**
   ☐ Spouse
   ☐ Domestic Partner
   ☐ Relative
   ☐ Friend
   ☐ Employee/Someone hired to assist

[1]You must have been eligible for Medicare prior to 1/1/2020 to apply for Plan F. Only applicants **first** eligible for Medicare before 1/1/2020 may purchase and be enrolled in Plan F. If enrollment in Plan F occurs for an applicant later found not eligible for Plan F, the applicant will be automatically enrolled in Plan G.

[2]If yes is marked and you do not complete the rest of this section, you will not be eligible for the discounted premium.

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2. Select your **Avesis Silver Vision & Hearing plan**.

   Select one option below (required)
   ☐ Silver Vision & Hearing 100
   ☐ Silver Vision & Hearing 130
   ☐ I do not want Silver Vision & Hearing (existing Silver Vision & Hearing will be canceled)

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.

H. Answer the following questions about your past and current coverage.

Please answer all questions.

(Answer questions below by marking YES or NO with an "X".) To the best of your knowledge:

☐ Yes ☐ No **H1.** Are you covered for medical assistance through the state Medicaid program?
(NOTE TO APPLICANT: If you are participating in a "spend-down program" and have not met your "share of cost," please answer NO to this question.)
If yes,

☐ Yes ☐ No (a) Will Medicaid pay your premiums for this Medicare supplement policy?

☐ Yes ☐ No (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

H. Answer the following questions about your past and current coverage, cont'd

☐ Yes ☐ No **H2.** Have you had coverage from any Medicare plan other than Original Medicare within the past 63 days (this includes a Medicare Advantage plan, a Medicare Cost plan or a Medicare HMO or PPO)?

If yes,

(a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

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

(b) With what insurance company, and what kind of policy?

_____

_____

☐ Yes ☐ No (c) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? **If yes, you must complete "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage" on the last page of this application.**

☐ Yes ☐ No (d) Was this your first time in this type of Medicare plan?

☐ Yes ☐ No (e) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

(f) If yes, with what insurance company was your Medicare supplement policy?

_____

☐ Yes ☐ No **H3.** Do you have another Medicare supplement policy in force with any carrier including Wellmark?

If yes,

(a) With what insurance company, and what plan do you have?

_____

☐ Yes ☐ No (b) Do you intend to replace your current Medicare supplement policy with this policy? **If yes, you must complete "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage" on the last page of this application.**

(c) If yes, what is the paid-to or expiration date of your policy? _____/_____/_____

☐ Yes ☐ No **H4.** Have you had coverage under any other health insurance within the past 63 days? (This includes an employer, union, or individual plan.)

If yes,

(a) With what insurance company, what kind of policy, and employer name (if applicable)?

_____

_____

(b) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank.

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

I. Choose your method of payment.

Select how you would like to pay for your MedicareBlue Supplement premiums from one of the options below. Billing periods are based on a calendar year. Please do not send payment with this application. If the bank account holder is not present to sign the application, you will need to complete and submit an Automatic Payment Authorization Form (M-5779).

I. Choose your method of payment, cont'd.

Payer's Billing Information (if different from applicant's mailing address):

Payer's Name:		
Payer's Mailing Address Line 1 *(Include Street, Bldg Name/No., Apt. No.)*		
Payer's Mailing Address Line 2 *(PO Box)*		
City	State	ZIP

☐ I1. **Direct bill.** On what basis? ☐ Quarterly ☐ Semi-annually ☐ Annually

☐ I2. **Automatic account withdrawal from applicant's account**

☐ I3. **Automatic account withdrawal from account other than applicant's**

If you selected payment method I2 or I3, 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 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.

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 next scheduled withdrawal.

Statements

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, 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 Medicare supplement policy.
4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of being notified of Medicaid eligibility. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance 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).

Application Agreement and Certification

My signature on this application verifies that I have received the "MedicareBlue Supplement Outline of Coverage," the "Guide to Health Insurance for People with Medicare," (available at Wellmark.com/guidetomedicare or, upon my request, from my agent in printed copy) and a completed copy of this application. My signature also verifies that I have read and understand the "Statements" section that appears above.

My signature verifies that, to the best of my knowledge and belief, I have answered the questions on this application truthfully and completely. My signature also verifies that I am enrolled in both Medicare Part A and Medicare Part B and I am a legal resident of South Dakota. I understand that my coverage will not begin until Wellmark Blue Cross and Blue Shield of South Dakota receives and accepts this application and applicable payment and assigns an effective date of coverage. If I answered "No" to the tobacco question on this application, I am eligible for a special tobacco non-user premium. If this status changes, I must notify Wellmark immediately. Wellmark may require me to recertify this status in the future.

My signature further verifies that I understand South Dakota law prohibits knowingly selling more than one Medicare supplement policy to an individual. I certify that if I currently have a Medicare supplement policy in force, I will cancel my current Medicare supplement policy upon notification of acceptance for coverage by Wellmark Blue Cross and Blue Shield of South Dakota. I can request that a Wellmark Blue Cross and Blue Shield of South Dakota representative review my existing policies and advise whether this MedicareBlue Supplement policy will duplicate the benefits of my existing health insurance policies by calling (877) 877-8411.

My signature also verifies that I authorize any health care provider to release medical records to Wellmark Blue Cross and Blue Shield of South Dakota 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.

If a condition arises that would have caused an ordinary prudent person to seek medical advice, diagnosis, care or treatment or a condition arose for which medical advice, diagnosis, care or treatment was received or recommended, regardless of the date I signed the application or the date the application was acted upon by Wellmark, I will so inform Wellmark by sending this information in writing to:
Wellmark Blue Cross and Blue Shield of South Dakota
PO Box 5023, Mail Station 338
Sioux Falls, SD 57117-5023

I understand that premium payments may be made on a calendar month, calendar quarter, semi-annual calendar year or calendar year basis. For example, a monthly premium payment would be for the first day of a month through the last day of such month. A quarterly premium payment would be for any calendar quarterly period, such as January 1 through March 31. A semi-annual premium would be for the period of either January 1 through June 30 or July 1 through December 31. An annual premium payment would be from January 1 through December 31 of the applicable year.

In the event I choose to pay my premium on a quarterly, semi-annual, or annual basis and there is a mid-year increase in the amount of premium(s), I will have the following responsibility with regard to an increase in premium(s).

- Quarterly payments: For quarterly premium payments, I must pay the remaining quarterly premium payments that include the premium increase.
- Semi-annual payments: For semi-annual premium payments, I must pay a bill for a premium payment that equals the difference between the new semi-annual premium amount and the previously paid first semi-annual premium amount. I also will be required to pay a second semi-annual premium amount that includes the premium increase.
- Annual payment: For annual premium payments, I must pay a bill for a premium payment that equals the difference between the new annual premium amount and the previously paid annual premium amount.

My signature additionally verifies that I understand and agree that the amount of my periodic premium payment 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), my age, changes in tobacco user status, or other factors that require adjustments to the total premium. These changes may occur at times other than an 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. 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.

Acknowledgement
I have read and understand the "Statements" and "Application Agreement and Certification" sections on this application. If I am replacing my current coverage, I have completed "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage." I hereby confirm the authority of Wellmark to make automatic withdrawals from my deposit account as set forth above under "Choose your method of payment" and that this authorization supersedes and replaces any previous authorization given by me with respect to such authority. I understand that any payment will be deposited immediately upon Wellmark's receipt of this application. I understand that Wellmark can change my premium at any time. If I am applying for coverage within 60 days of a premium change with an effective date prior to the premium change, Wellmark will provide notice of the new premium within a reasonable period of time after the enrollment of my application.

The information in this application is correct to the best of my knowledge. I understand that if I intentionally provide false information in this application, I will be disenrolled from the plan.

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.

By signing this application, submitting it to Wellmark or a Wellmark agent, and paying the premium amount due, I agree to all the terms and conditions stated herein and if applicable, I authorize the Wellmark independent agent or agency identified in this application to enter this information in Wellmark's online application or enrollment system.

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 _____/_____/_____

For Agent Only: List all health insurance policies you have sold to the applicant in the last five years, including those no longer in force.

Company	Policy Number	Type of Policy	In Force? (Y/N)

By signing and submitting this enrollment application, I certify that:

1. I am a licensed authorized Wellmark agent or agency.
2. I have obtained the enrollment information directly from the individuals named and have their express permission to submit the information electronically to Wellmark.
3. I am maintaining a retrievable record of this application signed by the consumer and all other records of this transaction in compliance with applicable law for 11 years. These records will be made available to Wellmark upon request.
4. I have disclosed that I am an authorized agent of Wellmark and that I may receive compensation in the form of commission for assisting with the sale and enrollment of this insurance policy.
5. I have not signed any forms as the applicant or enrollee.
6. I have disclosed to the applicant or legal guardian or power of attorney that supporting documentation may be required to process this enrollment and that coverage is not effective until Wellmark receives payment of premium.

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

Agent Signature_____ Date _____/_____/_____

Agent ID __ __ __ __ __ __ __ __ __ Farm Bureau County 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 application to:

Wellmark Blue Cross and Blue Shield of South Dakota
PO Box 5023, Mail Station 338
Sioux Falls, SD 57117-5023

Email: updatesindividualmembership@wellmark.com

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy issued by Wellmark Blue Cross and Blue Shield of South Dakota Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER OR ISSUER'S AGENT:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan.

The replacement policy is being purchased for the following reason (you MUST check one):

☐ Additional benefits.
☐ No change in benefits, but lower premiums.
☐ Fewer benefits and lower premiums.
☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

_____

☐ Other (please specify): _____

1. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
2. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Agent, Broker, or Other Representative:_____

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 _____/_____/_____

Wellmark Blue Cross and Blue Shield of South Dakota
PO Box 5023, Mail Station 338
Sioux Falls, SD 57117-5023

Email: updatesindividualmembership@wellmark.com