Wellmark South Dakota

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

Individual Health Plan Contract Change Form
(for grandfathered plans and pre-ACA non-grandfathered plans)

Effective Date _____/_____/_____

INSTRUCTIONS

- Please use a ballpoint pen to complete the required information as indicated in Section A.
- For guidelines regarding changes to your policy, please refer to the "South Dakota Individual Under-65 Market Enrollment and Administrative Guide" or contact Customer Services using the phone number on the back of your Wellmark ID card.
- If the policyholder is under age 18, the signature and relationship of a parent or legal guardian is required. Please provide proof of guardianship. If this form is for children only, the policyholder must be the youngest child.
- Wellmark must receive this form within the annual open enrollment period or within a special enrollment period. If this application is received later than 15 days after your signature date, eligibility for requested coverage and effective date are subject to change.
- Please submit the completed form (pages 1 through 5) to:

Email to: updatesindividualmembership@wellmark.com **OR** Mail to: Wellmark Blue Cross and Blue Shield of South Dakota
PO Box 5023, Mail Station 338
Sioux Falls, SD 57117-5023

A. TYPE OF CHANGE (MARK ALL THAT APPLY)

- ☐ Removing policyholder (complete sections B, C, D, E, G, I, K and L)
- ☐ Remove a member (complete sections B, C, and L)
- ☐ Member moving to new policy (complete sections B, C, D, E, G, H, I, K and L)
- ☐ Adding an eligible individual (complete sections B, C, E, G, H, K and L)
- ☐ Updating tobacco use status (complete sections B, G and L)
- ☐ Updating address/phone number (complete sections B, D and L)
- ☐ Changing benefits to a less rich level (complete sections B, F and L)
- ☐ Remove contraceptive coverage (complete sections B, H and L)
- ☐ Changing billing options (complete sections B, I and L)
- ☐ Cancellation of policy (complete sections B, J and L)

B. 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.

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.)

C. 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 reached 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) to be removed**:_____

Cancellation date will be as applicable:

- Date of death for 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
- Last day of the month prior to the start of employer group coverage
- Last day of the month prior to the start of Medicaid coverage

C. MAINTAINING COVERAGE, cont'd

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: _____/_____/_____

D. POLICYHOLDER INFORMATION (If converting 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)

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

Telephone Number ( )	Email Address:

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

List ALL persons to be covered & their relationship to the policyholder Name (First, MI, Last)	**Relationship**	**Date of Birth**	**Social Security Number / Tax Identification Number[1]**	**Gender**	**Full-time Student[2]**	**Disabled[2]**
Policyholder	*Self*			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
Spouse	*Spouse*			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
Dependent 1				☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
Dependent 2				☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No

☐ 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.

F. CHANGING BENEFITS (Not available for new sales) Complete this section to change your benefits. You must be a resident of South Dakota.

1. You may move to a less rich plan at any time during the year.
2. You may apply for an ACA (Affordable Care Act) plan during an open enrollment or within a special enrollment period.

1. Select your health plan option by placing a check mark in the box prior to the benefit. To determine which plans may be available to you, call your authorized agent; if you do not have an authorized agent, please call the Wellmark Customer Service number on the back of your ID card.
2. Select a first of the month effective date: ___/_1_/_____. The earliest available effective date is the first of the month following your signature date. If you do not list an effective date, the first of the month following your signature date will be assigned. (If you do not check to remove contraceptive coverage in section H, Wellmark will assign the benefit as covered in your existing plan, if applicable.)

Blue Select ☐ 1000 (Plan 3) ☐ 1500 (Plan 8) ☐ 2500 (Plan 6) ☐ 5000 (Plan 7)	**Blue Select Plus** ☐ 2000 ☐ 2500 ☐ 5000 ☐ 7500
Blue Priority HSA ☐ HSA A 1550 ☐ HSA B 2550	**Blue Select Basics** ☐ 1500 ☐ 3000
Classic Blue ☐ 2500 (Plan IV)	

F. CHANGING BENEFITS, cont'd (Not available for new sales) Complete this section to change your benefits. You must be a resident of South Dakota.

As a Wellmark contract holder, you will receive a Coverage Manual that contains important information about your coverage. You can also access Wellmark.com/inform to help you make the best decisions for you and your family. This site includes important information on your prescription drug coverage, like the accessibility and availability of prescription drugs, how to request a current drug list and the process for requesting an exception to the drug list. You also an find a list of participating providers and facilities and how to obtain a prior authorization. For more information, or if you have any questions, you can call the Wellmark Customer Service number listed on the back of your ID card.

G. TOBACCO DECLARATION

☐ Yes ☐ No I, my spouse or my dependent(s) (if included on this form) have used tobacco during the 12 months immediately preceding the signature date on this form.

If yes, please indicate name and relationship: _____

H. REMOVE CONTRACEPTIVE COVERAGE

To remove contraceptive coverage, please check the box.

☐ **Contraceptives** *(Available with grandfathered plans only. Contraceptive coverage is included with non-grandfathered plans.)*

I. 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 premium 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 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.

J. 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. 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.

K. 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.

L. AUTHORIZATION, CERTIFICATION AND SIGNATURE

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 on this form. I have further 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 the change requested will not start until this form and the appropriate premium payment amount are received and accepted by Wellmark.

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 them 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 and 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 K for effective date information.

Tobacco User Statues
If I answered "No" to the Tobacco Declaration listing on this form, I understand that I am eligible for a special tobacco non-user rate. If this status changes, I must notify Wellmark immediately. Wellmark may require recertification of this status in the future. If Wellmark determines within the initial two years that this status is incorrect, it will retroactively collect historical differences in premiums before claims will be paid, and the tobacco user rate will be applied on the first of the month following receipt of this information.

Eligibility
If I become enrolled in Medicare during the term of the 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
Payments for premiums and fees may be made on a calendar month, calendar quarter, semi-annual calendar year or calendar year basis. For example, a monthly payment for premiums and fees would be for the first day of a month through the last day of such month. A quarterly payment would be for any calendar quarterly period, such as January 1 through March 31. A semi-annual payment would be for the period of either January 1 through June 30 or July 1 through December 31. An annual payment would be for January 1 through December 31 of the applicable year.

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

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

L. AUTHORIZATION, CERTIFICATION AND SIGNATURE, cont'd

I understand and agree that Wellmark can change my payment amount at any time and the amount of my periodic premium payment and fee 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), the number of covered family members, members' ages, changes in tobacco user status, or other factors that require adjustments to the total premium and fees. These changes may occur at times other than an annual or other policy renewal.

If I have elected to authorize automatic premium withdrawals for payment from a deposit account, I understand that, depending upon the timing of when my application is received and processed, Wellmark reserves the right to withdraw the appropriate amount necessary (including multiple months of payments) to bring my account current with the next regularly scheduled automatic payment. Wellmark will not withdraw any amount above that which is due at the time of withdrawals. Notice may not be provided to me prior to this withdrawal. I understand and agree that I will not receive a paper billing statement but that should I want to be notified of amounts being withdrawn, I can do so by viewing my bill on *Wellmark.com* prior to my chosen withdrawal date. By visiting *Wellmark.com*, I can also choose to subscribe to an e-mail notifying me when new billing statements are available which will include my withdrawal amount.

I further understand and agree that the automatic withdrawal will change periodically to correspond with the applicable premium and fees. My authorization for automatic 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 may also be charged a returned payment fee of $25 for any automatic withdrawal that is not honored by my bank.

I also understand and agree that, 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 rate within a reasonable period of time after the enrollment of my application.

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 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.

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.

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.

I have confirmed with all persons named in this contract change form that my signature is binding to secure coverage. I have further confirmed with all persons named in this contract change form that in the event I am not eligible for or removed from the coverage and/or the family coverage is divided into multiple policies, my signature is binding to secure coverage. Any payment will be deposited immediately upon Wellmark's receipt of this contact change form.

Existing Policyholder Signature X _____ Date _____/_____/_____

Converted Policyholder Signature X _____ Date _____/_____/_____

Parent/Legal Guardian Signature (if applicant is a minor) X _____ Date _____/_____/_____

Parent/Legal Guardian Printed Name and relation to applicant _____

Agent Printed Name X _____ Agent No. __ __ __ __ __ __ __ __

Agent Signature (if applicable) X _____ Date _____/_____/_____

Farm Bureau County Number _____

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

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