State of Iowa Retiree Application
Programs N and F

Wellmark Blue Cross and Blue Shield of Iowa is an Independent Licensee of the Blue Cross and Blue Shield Association.

Iowa Department of Administrative Services
Human Resources Enterprise - Group Insurance
Hoover State Office Building - Level A
1305 E Walnut
Des Moines, Iowa 50319

APPLICANT: DO NOT COMPLETE SHADED AREA

Group No. Key	Effective Date
38073 (Basic) **38073-GOLD (Plus)**	_____/_____/_____

A. NAME, ADDRESS AND COVERAGE

Name (Last) (First)			
Telephone No.	Social Security No. (Required)	Gender ☐ Male ☐ Female	Birth Date _____/_____/_____
Residence (No., Street or RFD No., City, State, Zip)	County No.	Soc. Sec Disabled? ☐ Yes ☐ No	Medicare Enrolled? ☐ Yes ☐ No
Email Address			

Type of Benefits Desired ▶	Please select one of the retiree programs. Coverage begins on the assigned effective date. ☐ **Program N** ☐ **Program F**	Please select one. ☐ **Basic** ($10/$30/$50 - Generic only in gap) ☐ **Plus** ($10/$25/$40)

You must complete a separate enrollment form for your prescription drug coverage.

B. EVENT(S) OR REASON(S) FOR CHANGING CONTRACT

☐ Married ☐ Annual Enrollment ☐ Divorce	☐ Loss of Other Coverage ☐ Eligible for Medicare ☐ Other	Date Of Event _____/_____/_____	Explanation:

C. MEDICARE COVERAGE

Name of Person Covered by Medicare	Effective Date (Part A)
Medicare ID (HIC) No.	Effective Date (Part B)

D. OTHER CARRIER INFORMATION

If you have hospital, medical or prescription drug coverage insurance through another group plan (either directly or through your spouse) where the employer or group sponsor pays any portion of the cost or makes payroll deductions, please complete the following:

Will you keep the other health coverage in addition to this Wellmark coverage? ☐ Yes ☐ No

Policy no.: _____

Name (First, Last): _____

Employer (if applicable): _____

Insurance Company/HMO Name and Address: _____

Who is covered by the other health plan?
☐ Self ☐ Spouse

Effective Date:
_____/_____/_____

E. WAIVER OF ENROLLMENT (PLEASE COMPLETE IF YOU ARE WAIVING HEALTH BENEFITS)

☐ I waive health coverage for myself. Please indicate one of the following reasons:

☐ I have coverage under another health care benefit plan. ☐ I do not wish to enroll in the health plan.

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* Please retain a copy of this application for your records.

F. METHOD OF PAYMENT

Select how you would like to pay for your 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).

☐ **1. Direct Bill.**
If so, on what basis? ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

☐ **2. Use billing information on file with Wellmark.** (Available only for those with current State of Iowa retiree coverage.)

☐ **3. Automatic Account Withdrawal from Applicant's account.**

☐ **4. Automatic Account Withdrawal from account other than Applicant's.**

If you selected payment method 3 or 4, please complete the following:

On what basis? ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually
Date of withdrawal: ☐ 1st of the month ☐ 5th of the month
From: ☐ Checking *(Attach voided check.)*
☐ Savings

Financial Institution Name: _____

Financial Institution Phone Number (optional): _____

Bank Account Name(s) (exactly as it appears on the account): _____

Financial Institution Routing Number (9 digits): _____

Account Number: _____

State Code (found on your check on the top right corner above the date--e.g., 78): _____

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

If Direct bill is ***not*** selected:
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 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 Authorization 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 scheduled withdrawal.

AUTHORIZATION AND CERTIFICATION

I certify that I am legally authorized to apply for coverage. I understand that I am making application for the coverage sponsored by the State of Iowa offered by Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa (referenced herein as "Wellmark"). I understand that written notice of rate changes will be furnished by the State of Iowa as my agent. I further understand that the coverage applied for will not start until after this application and the appropriate premiums are received and accepted by Wellmark and an effective date of coverage is established by Wellmark.

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 the 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), or other factors that require adjustments to the total premium. These changes may occur at times other than an annual 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.

I certify that, after this application was completed, I carefully and fully read it, that the statements 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 on the completeness and truthfulness of the information given and the statements made, and that if I have intentionally made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, Wellmark will be entitled to declare the contract applied for void and to refuse allowance on benefits to any person thereunder.

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

Signature _____ Date _____/_____/_____

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