



## Employee Application for Health Insurance (for Non-ACA Groups)

- ☐ Excavating - 0000  
☐ Industrial - 0002  
☐ Philipp's Trucking - 0003

☒ Large Group  
Wellmark Blue Cross and Blue Shield of Iowa  
Fax: (515) 376-9047

☐ Small Business and Mid-Size Groups  
Wellmark Blue Cross and Blue Shield of Iowa  
Fax: (515) 376-9042

Failure to fill out this application completely  
may result in a delay of coverage.

☐ Open Enrollment Period ☐ Newly Eligible ☐ Special Enrollee ☐ Change

### A. Employer Information (Completed by Employer)

Group/Billing Unit No. 36729 Department No. \_\_\_\_\_ Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employer Name Bill Whitters Construction Phone Number ( 319 ) 848-7513  
Employer Address Line 1 (Street Address or Suite#) 1303 Hickory Hollow Rd NE  
Employer Address Line 2 (PO Box, Street Address) \_\_\_\_\_  
City Solon State IA ZIP 52333

### B. Employee Information

Name (First, MI, Last) \_\_\_\_\_  
Address Line 1 (Street Address or Apt/Suite#) \_\_\_\_\_  
Address Line 2 (PO Box, Street Address) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Home Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_ Ext. \_\_\_\_\_  
Email Address (optional) \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy) Gender: ☐ Male ☐ Female  
Status: ☐ Single ☐ Married ☐ Common law ☐ Domestic partner (Certification of Domestic Partnership form, M-4328, required)  
Social Security Number/Tax Identification Number \_\_\_\_\_  
(Social Security Number (SSN) or Tax Identification Number (TIN) must be provided.)  
Date of Hire (required) \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy)  
Employment Status: ☐ Full-Time ☐ Part-Time ☐ COBRA ☐ Retiree ☐ Seasonal  
Health: ☐ Employee ☐ Employee/spouse or domestic partner ☐ Plan 1 - \$1500  
☐ Employee/child(ren) ☐ Employee/spouse or domestic partner/child(ren) ☐ Plan 2 - \$2000  
Health Plan Code: ☐ Alliance Select ☐ Blue Advantage Deductible Amount: ☐ Plan 3 - \$2000

As a Wellmark contract holder, you will receive a Summary of Benefits and Coverage (SBC) that outlines important information about your coverage. You can also access [Wellmark.com/Inform](http://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 can find a list of participating providers and facilities, and how to obtain prior authorization. For more information, or if you have any questions, you can call the Wellmark Customer Service number located on the back of your ID card.

### C. Waiver of Enrollment (Please complete if you are waiving health benefits.)

- ☐ I waive health coverage for my dependents and myself. Please indicate one of the following reasons:  
☐ I (We) have coverage under another health care benefit plan.  
☐ I (We) do not wish to enroll in the health plan.

Please see the Important Information Regarding Waiver of Enrollment section on page 3 of this application.

Employee Name (First, Last)	Social Security Number / Tax Identification Number
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**D. Enrollment Reason or Event**

**Special Enrollment Event Reason:**

<input type="checkbox"/> Birth <input type="checkbox"/> Marriage/common law <input type="checkbox"/> Divorce/dissolution of domestic partnership <input type="checkbox"/> Adoption or placement for adoption <input type="checkbox"/> Court-ordered coverage <input type="checkbox"/> Legal guardianship	<input type="checkbox"/> Foster child placement <input type="checkbox"/> Involuntary loss of creditable coverage <input type="checkbox"/> Permanent move to Iowa <input type="checkbox"/> Returning from military service <input type="checkbox"/> Domestic partnership <input type="checkbox"/> Other _____
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List date of special enrollment event \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy) (or last day of coverage)

**E. Members/Enrollees Covered** If you need to list more than four dependents, please write all necessary information on a separate sheet of paper and attach to this application. Your employer determines eligibility for coverage. Please confirm with your employer that the dependent types listed below are eligible.

List Name (First, MI, Last) of all others to be covered	Date of Birth	Social Security Number/Tax Identification Number <sup>1</sup>	Gender	FT Student? <sup>2</sup>	Disabled? <sup>2</sup>
Spouse or Domestic Partner	/ /	a. <input type="checkbox"/> SSN/TIN _____ b. <input type="checkbox"/> Does not have an SSN/TIN c. <input type="checkbox"/> I refuse to provide the SSN/TIN	<input type="checkbox"/> Male <input type="checkbox"/> Female	N/A	<input type="checkbox"/> Yes
Dependent	/ /	a. <input type="checkbox"/> SSN/TIN _____ b. <input type="checkbox"/> Does not have an SSN/TIN c. <input type="checkbox"/> I refuse to provide the SSN/TIN	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Dependent	/ /	a. <input type="checkbox"/> SSN/TIN _____ b. <input type="checkbox"/> Does not have an SSN/TIN c. <input type="checkbox"/> I refuse to provide the SSN/TIN	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Dependent	/ /	a. <input type="checkbox"/> SSN/TIN _____ b. <input type="checkbox"/> Does not have an SSN/TIN c. <input type="checkbox"/> I refuse to provide the SSN/TIN	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Dependent	/ /	a. <input type="checkbox"/> SSN/TIN _____ b. <input type="checkbox"/> Does not have an SSN/TIN c. <input type="checkbox"/> I refuse to provide the SSN/TIN	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

<sup>1</sup>The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Wellmark or your employer will follow up with you to collect this information if you do not complete a., b., or c. for each person listed. Failure to provide the SSN/TIN information may result in a monetary penalty, per violation, assessed to you by the IRS.

<sup>2</sup>If your plan covers dependent(s) age 26 or older, they must be unmarried and either a full-time student or a disabled dependent. Please contact your Wellmark representative for more information.

Employee Name (First, Last)	Social Security Number / Tax Identification Number
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**F. Medicare Coverage (Required)**

☐ Yes ☐ No Are you and/or anyone listed in Section E Social Security disabled?  
If yes, list names \_\_\_\_\_

☐ Yes ☐ No Are you and/or anyone listed in Section E enrolled in Medicare?  
If yes, complete the following as appropriate:

Employee Name (as it appears on Medicare card)	Medicare ID
Effective Date (Part A) ____/____/____	Effective Date (Part B) ____/____/____
Spouse or Domestic Partner Name (as it appears on Medicare card)	Medicare ID
Effective Date (Part A) ____/____/____	Effective Date (Part B) ____/____/____
Dependent Name (as it appears on Medicare card)	Medicare ID
Effective Date (Part A) ____/____/____	Effective Date (Part B) ____/____/____

**G. Other Carrier Information (Required)**

☐ Yes ☐ No Will you, your spouse or domestic partner, or your dependents keep other health coverage in addition to this Wellmark, Inc. coverage?  
If yes, please complete the following:

Policyholder Name (First, Last) \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Please list those covered by the other health plan(s) \_\_\_\_\_

Policy No. \_\_\_\_\_ Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer Name (if coverage is through employer group) \_\_\_\_\_

Insurance Company/HMO Name \_\_\_\_\_

Address Line 1 (Street Address or Suite#) \_\_\_\_\_

Address Line 2 (PO Box, Street Address) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone Number (if known) (\_\_\_\_) \_\_\_\_\_

Is there a divorce decree/court order that requires one parent to provide health insurance coverage for any dependent?  
☐ Yes ☐ No If yes, please complete the following:

List dependent(s) \_\_\_\_\_

List name of person required to provide health insurance \_\_\_\_\_

List name of person who has primary physical custody \_\_\_\_\_

**H. Important Information Regarding Waiver Enrollment**

If you are declining enrollment for yourself or your dependents (including your spouse or domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within a period of time specified by your Plan after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within the time specified by your Plan after the marriage, birth, adoption, or placement for adoption. Additionally, you must enroll within the time specified by your employer after you lose eligibility for coverage under Medicaid or CHIP or become eligible for Medicaid or CHIP premium assistance.

Employee Name (First, Last)	Social Security Number / Tax Identification Number
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## H. Important Information Regarding Waiver Enrollment, cont'd

Please note that if you or your dependents are not covered by minimum essential coverage, you may be responsible for individual shared responsibility payments when filing your federal income tax return. Also, by declining the coverage offered by your employer, you or your dependents may not be eligible for Marketplace coverage subsidies.

To request special enrollment or obtain more information, refer to your Summary Plan Description (SPD), coverage manual, other benefit documents, or contact your employer.

## I. Authorization and Certification

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I understand that I am completing this application for the coverage sponsored by my employer or group sponsor and offered by Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa, or Wellmark Health Plan of Iowa, Inc. (each referenced herein as "Wellmark"). I authorize my employer, as my agent, to deduct from my pay or collect from me in advance the monthly rates therefore and remit such sums to Wellmark on my behalf. This authorization is to remain in effect until Wellmark is notified by me or my employer to the contrary. I understand that written notice of rate changes will be furnished to my employer as my agent. I further understand that the coverages applied for will not start until after this application and the appropriate coverage rates are received and accepted by Wellmark and an effective date of coverage is established by Wellmark.

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 made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, Wellmark will be entitled to declare the contracts applied for void and to refuse allowance on benefits to any person thereunder.

I acknowledge I have received or have been advised and understand I will receive from my employer the Summary of Benefits and Coverage (SBC).

### 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 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. 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.

### HSA Coverage

If the High Deductible Health Plan that I have selected is combined with a Health Savings Account (HSA), I understand that enrolling in such coverage does not guarantee that I am or will be eligible to make contributions to an HSA or that contributions can be made to an HSA on my behalf.

### Consent to receive Marketing Information and Solicitations Via Residential Telephone, Cellular Phone, Text and Email Messages

By checking the box later in this application and entering my signature on this application, I hereby provide my consent to Wellmark to contact me about 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 services. I understand I may revoke this consent at any time by calling the number located on the back of my Wellmark ID card.

### Consent to Electronic Delivery of Information

By checking the box later in this application and entering my signature on this application, I hereby provide my consent to Wellmark to deliver important notices and information about my health plan and coverage electronically. I understand I am being asked to consent to notices and documents being delivered to me electronically. My consent applies to notices and documents relating to my health insurance coverage ("Coverage") with Wellmark.

Employee Name (First, Last)	Social Security Number / Tax Identification Number
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## I. AUTHORIZATION AND CERTIFICATION, cont'd

### Right to Request for Paper Copies

I understand that I have the right to have a notice or document provided or made available in paper form at no cost. To obtain a paper copy of a notice or document delivered by electronic means or to withdraw consent, please call the number on the back of your ID card.

### Right to Withdraw Consent

I understand that I have the right to withdraw consent to have a notice or document delivered by electronic means. Such consent will be deemed withdrawn upon receipt by Wellmark of the request to withdraw consent. Any withdrawal of consent shall not affect the legal effectiveness, validity or enforceability a notice or document delivered by electronic means before the withdrawal of consent is effective. To withdrawal consent for electronic notice of documents please contact Wellmark by calling the number on the back of your ID card or select "unsubscribe" option located within the email message.

### Scope of Consent

This consent applies to all notices and documents relating to my Coverage, including, but not limited to:

- Explanation of Benefits;
- Disclosures and notices;
- Summary of Benefits and Coverage;
- Notices of cancellation, nonrenewal or termination;
- Benefits Policy, riders or endorsements;
- Responses to communications from you;
- Appeals correspondence;
- Billing and payment notices; and
- Other important information

### Hardware and Software Requirements

In order to access, view and retain documents electronically, I understand I must have access to a personal computer or other device capable of accessing the internet with a web browser, email or web service capabilities, the ability to receive and review attachments to emails and software which permits me to receive and access Portable Document Format (PDF) files and MS Word files. Free software to view PDF files is available from: <http://get.adobe.com/reader/>. I confirm that I have access to the hardware and software necessary to receive and review electronic records and I have an active email account with the ability to receive and access emails and email attachments in the formats described.

### NOTICE/DISCLAIMER

WELLMARK IS NOT RESPONSIBLE FOR ANY UNAUTHORIZED ACCESS BY THIRD PARTIES TO INFORMATION PROVIDED ELECTRONICALLY, INCLUDING, WITHOUT LIMITATION, ANY DIRECT, INDIRECT, SPECIAL, INCIDENTAL OR CONSEQUENTIAL DAMAGES RESULTING FROM SUCH UNAUTHORIZED ACCESS. WELLMARK ALSO IS NOT RESPONSIBLE FOR DELAYS IN TRANSMISSION OF NOTICES AND DOCUMENTS.

### CONSENT

By accessing or opening the documents sent to me via the email address provided, I certify that (1) I consent and agree to receive notices and documents electronically and confirm that I will download or print them for my records; and (2) I have the ability to access the information that is provided electronically via email communications.

- ☐ I give my permission to the licensed agent/licensed agency who is identified with this application to enter my application on line through Wellmark.com.
- ☐ I authorize Wellmark to contact me via residential telephone, cellular phone, text and/or email for marketing purposes (optional).
- ☐ I consent to receive important information electronically (optional).

I have read and understand the Important Information Regarding Waiver of Enrollment and Authorization and Certification language on this application and acknowledge receipt of a fully completed copy of this application.

Employee Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

# Required Federal Accessibility and Nondiscrimination Notice



## Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Wellmark does not exclude people or treat them differently because of their race, color, national origin, age, disability or sex.

## Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 5W189, Des Moines, IA 50309-2901, 515-376-4500, TTY 888-781-4262, Fax 515-376-9073, Email [CRC@Wellmark.com](mailto:CRC@Wellmark.com). You can file a grievance in person, by mail, fax or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail, phone or fax at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ກັບ. (TTY: 888-781-4262.)

주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, निःशुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deutsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တစ်ခုခုပြော-နားထောင်ကဏ္ဍကိစ္စ, ကိစ္စတစ်ခုခုတော့မေးတော့မေးတော့မေး, လာတော့လာတော့မေး, ဆိုလားနီလီလီ. ဆေးကုစီဆွဲ ၈၀၀-၅၂၄-၉၂၄, ၈၈၈-၇၈၁-၄၂၆၂ တက်ကု.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि निःशुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: ከማርኛ የሚናገሩ ከሆኑ፣ የቋንቋ አገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ደውሎ ያነጋግሩ።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maada. Hebir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yánílti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojí' hóline' 800-524-9242 doodaii' (TTY: 888-781-4262)