

**Rohan Phillips**

2015 S Ridge Dr  
Coralville, IA 52241

128 2<sup>nd</sup> Ave SW  
Cedar Rapids, IA 52402

P. 319 337 8871  
TF. 888 337 9746  
F. 888 530 7932

## Wellmark Short Term Application Process

1. Download and print the application form.
2. Complete the application in its entirety, answering all appropriate questions.
3. When application is complete, sign in the space provided.
4. Once all information has been completed, please return your application to the following address along with a check for the premium amount.
  - a. Solutions Insurance, Rohan Phillips, 2015 S Ridge Dr, Coralville IA 52241
  - b. If you are choosing to pay monthly, please be aware that there is a \$10 per month service fee. A check for the first months premium including the \$10 needs to be sent to get this application started.

If you have questions at any time through this process, please call Rohan Phillips of Solutions Insurance to get the assistance you need.

Rohan Phillips will call you once the application is received to go over details of the application process.

Thank you for choosing to use Solutions Insurance as your Independent Agent. We are here to make sure that you get the best health insurance for your needs.

Sincerely



Rohan Phillips



**Wellmark®**  
**BlueCross**  
**BlueShield**  
*of Iowa*

An Independent Licensee of the Blue Cross and Blue Shield Association

P. O. Box 9349 • Des Moines, Iowa 50306-9349

## Application For Short Term Major Medical Expense Policy

FB Membership No. and FB County No., if applicable

Group/Billing Unit

County #

**ELIGIBILITY CHECKLIST:** If you answer "yes" to any of the following eligibility questions, a policy cannot be issued.

1. Is any person to be covered younger than 15 days old?  No  Yes
2. Will you, or any person to be covered, become eligible for Medicare or Medicaid during the policy term?  No  Yes
3. Within the last five years, have you or any person to be covered:
  - a. been treated, diagnosed, or been advised to seek treatment for: heart or circulatory system disorder including hypertension, and high blood pressure; stroke; diabetes, cancer or tumor; alcohol abuse; drug abuse or chemical dependency?  No  Yes
  - b. been treated for or diagnosed with an immune system disorder including acquired immune deficiency (AIDS) or AIDS Related Complex (ARC) and/or tested HIV positive?  No  Yes
  - c. been declined for health insurance due to health reasons?  No  Yes
4. Are you, your spouse or any dependent now pregnant?  No  Yes
5. Do you or anyone else listed on this application currently have hospital and/or medical coverage through Wellmark Blue Cross and Blue Shield of Iowa, or any other company, that will not terminate prior to the effective date?  No  Yes

**MEMBERSHIP INFORMATION**

NAME OF PRIMARY APPLICANT (FIRST, MIDDLE, LAST)				SOCIAL SECURITY NO.		BIRTHDATE / /	
ADDRESS (INCLUDE STREET, BUILDING NAME/NO., APT. NO., CITY, STATE, ZIP)				HOME PHONE ( )		SEX <input type="checkbox"/> M <input type="checkbox"/> F	
Are you a resident of Iowa? <input type="checkbox"/> Yes <input type="checkbox"/> No						MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> COMMON LAW	
<b>List all other individuals to be covered, in addition to primary applicant.</b>				BIRTHDATE M / D / Y		SOCIAL SECURITY NO.	
First	MI	Last	Relationship			SEX <input type="checkbox"/> M <input type="checkbox"/> F	FULL-TIME STUDENT <input type="checkbox"/> Yes <input type="checkbox"/> No
				/ /			
				/ /			
				/ /			
				/ /			
				/ /			

**POLICY TYPE INFORMATION**

\*The effective date cannot be prior to or the same date as the date you sign this application.

THIS REQUEST FOR COVERAGE IS FOR: <input type="checkbox"/> SINGLE <input type="checkbox"/> TWO-PERSON <input type="checkbox"/> FAMILY	POLICY TERM MUST BE 30 DAYS AND NOT TO EXCEED 6 MONTHS Effective Date* _____ Termination Date _____	DEDUCTIBLE/OUT-OF-POCKET MAXIMUM <input type="checkbox"/> \$ 250 / \$1,000 <input type="checkbox"/> \$ 500 / \$1,500 <input type="checkbox"/> \$ 1,000 / \$3,000
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Primary Applicant Name (First, Middle, Last)	Social Security Number	Group/Billing Unit No.	Effective Date
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**PAYMENT INFORMATION**

CHECK ENCLOSED FOR ENTIRE POLICY TERM

MONTHLY AUTOMATIC ACCOUNT WITHDRAWAL\* (available only for policy durations of 3 months or more)

WITHDRAWAL ON 1ST OF THE MONTH

WITHDRAWAL ON 5TH OF THE MONTH

\*ADD \$10.00 PER MONTH TO THE MONTHLY PREMIUM AMOUNT, INCLUDING THE FIRST MONTH, IF USING THIS METHOD. FOR MONTHLY AUTOMATIC BANK PAYMENTS, YOUR POLICY MUST END ON THE FIRST DAY OF THE MONTH AND THE POLICY TERM CANNOT EXCEED 6 MONTHS OF COVERAGE.

DO YOU WANT IT DEDUCTED FROM:  SAVINGS  CHECKING--ATTACH A VOIDED CHECK

IF SOMEONE OTHER THAN PRIMARY APPLICANT IS PAYING THROUGH AUTOMATIC BANK WITHDRAWAL, PLEASE COMPLETE FORM M-5750 AUTHORIZATION FOR AUTOMATIC WITHDRAWAL.

PREMIUM SUBMITTED			<input type="checkbox"/> 1 <sup>ST</sup> ISSUANCE
\$			<input type="checkbox"/> 2 <sup>ND</sup> ISSUANCE

**EMPLOYER CONTRIBUTIONS**

Will your employer be paying any part of the premium for this certificate either directly or through wage adjustments or other means of reimbursement?  No  Yes If yes, check one item below:

Applicant is owner of a sole proprietor business  Employer is deducting the full premium from employee's payroll  Employee is part-time or temporary and not eligible for small employer coverage

Employer has only one eligible employee

Employer has been denied the opportunity to purchase insurance due to low participation/contribution (attach copy of denial)

Will your premium payments for this coverage be deductible on your federal income tax return as a trade or business expense other than the special health insurance deduction available to self-employed persons?  No  Yes

**AGREEMENT AND CERTIFICATION**

I certify that I am legally authorized to apply for coverage for myself and for all other persons named in this application. I understand that I am making application for the coverage offered by Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa (Wellmark), and that coverage will not start on the requested effective date until after this application and the premium submitted are received and accepted by Wellmark and the requested effective date is approved by Wellmark.

I certify that, after this application was completed, I carefully and fully read it, that the statement 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 upon 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 have concealed any material fact, Wellmark will be entitled to declare the health care policy void and to refuse allowance of benefits to any person thereunder.

**I understand that the coverage applied for will not pay benefits for any expense incurred for any pre-existing condition.** I understand that this is not a continuation of any previous coverage, including any prior Wellmark Blue Cross and Blue Shield of Iowa Short Term Major Medical policy.

I acknowledge that this policy does not meet the definition of qualifying previous coverage or qualifying existing coverage is defined in section 513C.3(15)(a), (b), or (c).

**I acknowledge receipt of a copy of this application, an outline of coverage, and a benefits policy.**

\_\_\_\_\_  
 APPLICANT SIGNATURE

\_\_\_\_\_  
 AGENT SIGNATURE

Rohan Phillips  
 \_\_\_\_\_  
 PRINT AGENT NAME

\_\_\_\_\_  
 DATE

\_\_\_\_\_  
 DATE

AGENT NO.  
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