

**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 Application Process

1. Download and print the application form and submission cover page in the pages following this one.
2. Complete the application in its entirety, answering all appropriate questions.
3. When completing the health questions, please supply all the requested information shown in the boxes below the check boxes.
4. When application is complete, sign in the space provided.
5. On the Submission Cover Page, fill in your name at the top and then sign in the space provided. If you are applying with your spouse, please also have your spouse sign. *Completing the submission cover page allows me to then submit your application electronically, this does speed up the process.*
6. Once all information has been completed, there are two methods to get your application started
  - a. Fax your application to Solutions Insurance, Toll Free 888 530 7932
  - b. Or Mail, Solutions Insurance, 2015 S Ridge Dr, Coralville IA 52241

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



# Submission Cover Page

## Health Insurance for Individuals and Families

Applicant Name: \_\_\_\_\_  
(Print) First M Last

Application ID: \_\_\_\_\_  
(Example: IAXXXXXXX)

Plan Name: \_\_\_\_\_

Please attach the following items to this page if applicable.

- Authorization for Automatic Account Withdrawal form (to be completed by Payor)
- Affidavit Common Law Marriages form

Your application for health insurance has been submitted to us electronically, so you don't need to send another copy to us.

My signature below certifies I am legally authorized to apply for coverage for all persons named in this application and I agree to comply with those terms outlined in the Agreement and Certification section of my online application. If this application is for dependent children only, dependents over age 18 must sign below. If any person listed on this application is under age 18, a parent/legal guardian must also sign below.

X

_____ Applicant Signature	_____ Date	_____ Relationship* (Please Print)
_____ Applicant Signature	_____ Date	_____ Relationship* (Please Print)
_____ Applicant Signature <i>R. D. Phillips</i>	_____ Date	_____ Relationship* (Please Print) 67000235
_____ Agent Signature	_____ Date	

\*Relationship: Self, Spouse, Parent, Step Parent, Foster Parent, Legal Guardian, Power of Attorney, Oldest Dependent, Other.

Send this cover page and the materials listed above to:

**Wellmark Blue Cross and Blue Shield**  
**Station 19**  
**636 Grand Ave**  
**Des Moines, IA 50309**  
**Fax: 515-235-4479**

Note: If this is the only documentation you are sending to us, please fax this page to the number above.

# Application for Individual Health, Dental & Life Insurance

## Instructions

- Please print your responses and use a ballpoint pen. Press hard for good copies.
- **If you are requesting first time coverage, be sure that all sections of the application are completed.**
- **If you currently have coverage and are making a change to an existing policy that decreases your level of benefits (i.e., increasing your deductible within the same plan option, moving to a plan option that has lesser benefits), or adds or removes a member due to an event listed on the back page, you may skip sections C, D, E, F, and G.**
- If this application is for children only, the applicant must be the oldest child.
- If the applicant is under age 18, the signature and relationship of a parent or legal guardian is required.
- **Wellmark must receive this application within 15 days of the date you signed it.**

## Checklist

- Did you indicate which health care plan you are applying for? *(See Section B, Enrollment Information.)*
- Did you indicate whether or not you are also applying for optional benefits?
- If you want your premium and service fee\* automatically deducted from your checking account, have you included a voided check?
- Have you checked “Yes” or “No” to each health question?
- Have you checked “Yes” or “No” to the tobacco user question for each person you listed?
- If you made any changes to this application, did you initial that change?
- Have you signed and dated the application?
- If you are a resident of Iowa but have an out-of-state address, please provide proof of residency, e.g., driver’s license, voter registration.

\*A component of your total cost is the service fee. This fee, charged on a monthly basis, reflects a portion of the administrative costs of reviewing, administering, and maintaining contracts.



An Independent Licensee of the Blue Cross and Blue Shield Association



An Independent Licensee of the Blue Cross and Blue Shield Association  
PO Box 9232 • Des Moines, Iowa 50306-9232



PO Box 1650  
Little Rock, Arkansas 72203-1650

Effective Date / /
Group/Billing Unit No.
Monthly Premium and Service Fee amount is:

**A. Membership Information**       **New Enrollment (complete all sections)**     **Change to Existing Coverage (see Instructions)**

Option 1 – Applicant enters an effective date \_\_\_\_/\_\_\_\_/\_\_\_\_       Option 2 – Wellmark assigns effective date  
(You will be billed from this effective date.)

Applicant Name (First, Middle, Last)      Marital Status:  Single     Married  
 Common Law (Notarized Affidavit Required)

IA Resident?  Yes  No    Daytime Phone: (    )      E-mail Address (optional)

Mailing Address	Street	Bldg Name/No., Apt. No.	PO Box	City	State	Zip
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Payor's Billing Information (if different from Applicant)    Payor Name:

Payor's Mailing Address	Street	Bldg Name/No., Apt. No.	PO Box	City	State	Zip
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List all persons to be covered				Birthdate	Social Security Number	Height	Weight	Gender	Full-time Student?	Disabled?*	Tobacco User?***
First	MI	Last									
Applicant								<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse								<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent								<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent								<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent								<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent								<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

\*Is disabled person(s) eligible for Medicare?     Yes     No  
 \*\*Answer yes if the person listed has used tobacco during the 12 months immediately preceding the date of this application.

If you answered "No" for any person listed on this application, that person is eligible for a special tobacco non-user rate. If this status changes, you must notify us immediately. We may require you to recertify this status in the future. If we determine within the initial two years that this status is incorrect, we will retroactively collect historical differences in premiums before claims will be paid, and we will start applying the tobacco user rate on the first of the month following our receipt of this information.

**B. Enrollment Information**

1. If you marked "Change to Existing Coverage" above and are making a change because of an event, do you want to maintain your current Wellmark Blue Cross and Blue Shield of Iowa policy with the same deductibles and benefits?     Yes     No

**If you currently have coverage and are making a change to an existing policy that decreases your level of benefits (i.e., increasing your deductible within the same plan option, moving to a plan option that has lesser benefits) or adds or removes a member due to an event listed on the back page, you may skip sections C, D, E, F, and G.**

If you are a new applicant or a current policyholder who wants to change plans, please check the Wellmark plan you are applying for:

<b>Alliance Select<sup>SM</sup> Comprehensive</b> <input type="checkbox"/> 500 <input type="checkbox"/> 1000 <input type="checkbox"/> 1500 <input type="checkbox"/> 3000 <input type="checkbox"/> 4500	<b>Alliance Select<sup>SM</sup> Enhanced</b> <input type="checkbox"/> 750 <input type="checkbox"/> 1250 <input type="checkbox"/> 2500 <input type="checkbox"/> 5500 <input type="checkbox"/> 9500	<b>Alliance Select<sup>SM</sup> Value</b> <input type="checkbox"/> 2000 <input type="checkbox"/> 5000	<b>Blue Basics</b> <input type="checkbox"/> 3000 <input type="checkbox"/> 5000	<b>Blue Priority<sup>SM</sup> HSA</b> <input type="checkbox"/> 1700A <input type="checkbox"/> 1700B <input type="checkbox"/> 2750A <input type="checkbox"/> 2750B <input type="checkbox"/> 5400A	Maternity (\$2500 Deductible): <input type="checkbox"/> Yes <input type="checkbox"/> No
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2. Please indicate "Yes" or "No" for each of the following Wellmark optional benefits. If you are not electing optional benefits, you must mark "No" to avoid a delay in the processing of your application.  
 Blue Dental     Yes     No      Supplemental Accident     Yes     No      Contraceptives     Yes     No  
 (not available with Blue Basics and HSA products)

3. Please indicate "Yes" or "No" for the following USable Life optional benefit? If you are not electing this optional benefit, you must mark "No" to avoid a delay in the processing of your application.  
 USable Life Insurance\*     Yes     No      *If yes, please complete section F.*

\*USable Life Insurance Company is an independent life insurance company that does not provide Wellmark Blue Cross and Blue Shield of Iowa products or services. USable Life Insurance Company is solely responsible for the life insurance coverage.

<b>For Office Use Only</b>			Date Received
Agent Name	Underwriting Approval	Underwriting	

Applicant Name (First, Middle, Last)	Social Security Number
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**B. Enrollment Information, cont'd**

4. If you are making a change to your existing coverage, check event(s) below that apply:  
 Adding/Removing Dependent    Marriage    Divorce    Medicare Eligible    Death    Birth    Other, Specify \_\_\_\_\_  
Name of Affected Party(ies): \_\_\_\_\_ Date of Event: \_\_\_\_/\_\_\_\_/\_\_\_\_

5. a. Will your premium and service fee 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?    Yes    No  
5. b. Will your employer be paying any part of the premium or service fee for this policy either directly or through wage adjustments or other means of reimbursement?  
 Yes    No  
If you answered yes to either 5a or 5b, check one item below:  
 Applicant is owner of a sole proprietor business    Employer has only one eligible employee  
 Employer is deducting the full premium and service fee    Employee is part-time or temporary and not eligible for small employer coverage  
 Employer has been denied the opportunity to purchase insurance due to low participation/contribution (attach copy of denial)

**C. Health Questions**

If anyone listed on this application has ever had any indications, signs, symptoms, diagnosis, treatment, or used any prescription or non-prescription medications for the following conditions, please put an "X" in the box under the columns marked "Yes" to the right of the condition described. If not, please put an "X" in the column marked "No" to the right of the condition described. **If you change your answer, you must initial the change.**

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
ALS (Lou Gehrig's Disease)			Kidney Dialysis/Failure			Peripheral Neuropathy		
Alzheimer's Disease/Dementia			Multiple Sclerosis			Peripheral Vascular Disease		
Cirrhosis of the Liver			Muscular Dystrophy			Scleroderma		
Coronary Bypass/Coronary Artery Disease/ Congestive Heart Failure/Heart Attack			Myasthenia Gravis			Sickle Cell Anemia		
			Neurogenic Bladder or Bowel			Stroke		
Crohn's Disease/Regional Ileitis			Organ Transplant Recipient, except corneal			Systemic Lupus Erythematosus		
Cystic Fibrosis			Pancreatitis, Chronic					
Emphysema/COPD			Parkinson's Disease					

Indicate person(s) who has condition(s): \_\_\_\_\_  
The presence of any of the conditions listed above may result in a decision by Wellmark not to offer coverage. If Wellmark does not offer coverage, the state of Iowa may provide coverage that does not require underwriting for those individuals who qualify. To request an immediate decision by Wellmark that may result in your ability to apply for state-sponsored plans, complete only section H.  
However, if the remaining family members wish to apply for coverage, please continue answering the health questions for the remaining family members.

**IN THE PAST 1 YEAR**, has anyone listed on this application had any indications, signs, symptoms, diagnosis, treatment, or used any prescription or non-prescription medications **for the following conditions? If you change your answer, you must initial the change.**

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
1. Gain or loss of fifteen or more lbs.			3. Hernia, except Hiatal			5. Pregnancy		
2. Gall Bladder Disorder			4. Meningitis					

**IN THE PAST 2 YEARS**, has anyone listed on this application had any indications, signs, symptoms, diagnosis, treatment, or used any prescription or non-prescription medications **for the following conditions? If you change your answer, you must initial the change.**

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
6. Acne			10. Carpal Tunnel Syndrome			14. Pap Smear, Abnormal		
7. Attention Deficit Disorder/Learning Disorder			11. Ear, Throat, Tonsil Disorders			15. Reproductive Organ Disorder		
8. Back Disorder			12. Frequent Headaches, Non-Migraine			16. Sinus Disorder		
9. Bladder Disorder			13. Menstrual Disorder			17. Thyroid Disorder		

**IN THE PAST 5 YEARS**, has anyone listed on this application had any indications, signs, symptoms, diagnosis, treatment, or used any prescription or non-prescription medications **for the following conditions? If you change your answer, you must initial the change.**

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
18. Allergies			23. Jaw Disorder/TMJ and/or TMD			27. Stomach, Esophageal Condition, Ulcer, Hiatal Hernia		
19. Asthma			24. Psychological/Mental/Nervous Condition					
20. Breast Disorder			25. Rectal Disorder			28. Tumor(s), Cyst(s) or Growth		
21. Colitis (other than Ulcerative/Crohn's)			26. Spastic Colon/Irritable Bowel Syndrome			29. Urinary Tract Disorder		
22. Fractures or Dislocations								

**IN THE PAST 10 YEARS**, has anyone listed on this application had any indications, signs, symptoms, diagnosis, treatment, or used any prescription or non-prescription medications **for the following conditions? If you change your answer, you must initial the change.**

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
30. Blood Disease/Disorder			31. Migraine Headaches			32. Sleep Disorders/Apnea		

Applicant Name (First, Middle, Last)	Social Security Number
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**C. Health Questions, cont'd**

**HAS ANYONE LISTED ON THIS APPLICATION EVER HAD** any indications, signs, symptoms, diagnosis, treatment, or used any prescription or non-prescription medications **for the following conditions? If you change your answer, you must initial the change.**

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
33. Alcohol/Substance Abuse			48. Gastric Bypass/Weight Loss Surgery			63. Paralysis		
34. Arthritis/Rheumatism			49. Genital Herpes/Syphilis/Sexually Transmitted Diseases			64. Prostate Disorder		
35. Bone Disease/Deformity			50. Hearing Impairment			65. Pulmonary Hypertension		
36. Bowel Disorder			51. Heart Disease or Murmur			66. Skin Disorder		
37. Cancer of any kind			52. High Blood Pressure			67. Spinal Disorder		
38. Cholesterol or Lipid Disorder			53. HPV/Genital Warts/Human Papilloma Virus			68. Tuberculosis+TB test		
39. Circulatory Disorder			54. Infertility and/or Testing			69. Ulcerative Colitis		
40. Congenital Disease/Defects			55. Joint Disorder			70. Varicose Veins		
41. Diabetes			56. Kidney Disorder			71. Vein or Artery Disease, Other		
42. Disfiguring Scars			57. Liver Disorder/Hepatitis			72. Please list any other conditions not previously mentioned:		
43. Eating Disorders			58. Loss of Limb(s)					
44. Endometriosis			59. Lung/Respiratory Disorder					
45. Epilepsy/Seizure			60. Mental Retardation					
46. Eye Disorder/Disease (other than corrective lenses)			61. Neurological Disease/Disorder					
47. Foot Disorder			62. Pancreatic Disorders/Acute Pancreatitis					

- Yes  No 73. Has anyone had medical treatment or advice from a doctor, chiropractor, psychologist or therapist, or any other health care professional or taken any prescription or non-prescription medications for any conditions not listed above within the last three years?
- Yes  No 74. Has future surgery, diagnostic testing or medical treatment been recommended for any person listed on this application?
- Yes  No 75. Has any person on this application ever been declined, postponed, charged an extra premium or had a portion of coverage excluded for life, disability or medical insurance or had such coverage rescinded?
- Yes  No 76. Has anyone listed on this application ever been diagnosed or treated for AIDS or AIDS Related Complex, or tested positive for HIV?

**IF YOU ANSWERED "YES" TO ANY OF THE ABOVE NUMBERED CONDITIONS OR QUESTIONS**, complete the following information about each condition. Insert additional pages if necessary.

Condition #	Person who has condition: <input type="checkbox"/> Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Name: _____	Date of Onset (Symptoms and/or Treatment) ____/____/____	Still under Treatment or Symptoms Still Present <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Ended (Symptoms and/or Treatment) ____/____/____
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Treatment recommended or rendered:	List prescription/non-prescription medications and dosages:
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List diagnostic and monitoring testing and lab results:	(Required for #5) Pregnancy Due Date: ____/____/____	(Required for #52) List most recent blood pressure reading: ____/____ Date Taken: ____/____/____
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Condition #	Person who has condition: <input type="checkbox"/> Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Name: _____	Date of Onset (Symptoms and/or Treatment) ____/____/____	Still under Treatment or Symptoms Still Present <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Ended (Symptoms and/or Treatment) ____/____/____
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Treatment recommended or rendered:	List prescription/non-prescription medications and dosages:
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List diagnostic and monitoring testing and lab results:	(Required for #5) Pregnancy Due Date: ____/____/____	(Required for #52) List most recent blood pressure reading: ____/____ Date Taken: ____/____/____
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Condition #	Person who has condition: <input type="checkbox"/> Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Name: _____	Date of Onset (Symptoms and/or Treatment) ____/____/____	Still under Treatment or Symptoms Still Present <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Ended (Symptoms and/or Treatment) ____/____/____
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Treatment recommended or rendered:	List prescription/non-prescription medications and dosages:
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List diagnostic and monitoring testing and lab results:	(Required for #5) Pregnancy Due Date: ____/____/____	(Required for #52) List most recent blood pressure reading: ____/____ Date Taken: ____/____/____
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In order to complete the underwriting process as soon as possible, Wellmark may need to contact you. Please indicate which would be the best method to use.

E-mail  Daytime Phone  Mailing Address  Evening Phone: \_\_\_\_\_  Fax: \_\_\_\_\_

Other: \_\_\_\_\_

**D. Condition Rider/Coverage Denial**

If you are offered:  a condition rider (excludes coverage for a specific condition) **OR**  a denial of coverage (One or more applicants will not be insured. If accepted, a policy will be issued for the remaining applicants.).

Wellmark should:  continue the underwriting process  not continue the underwriting process

Applicant/Agent Comments: \_\_\_\_\_

Applicant Name (First, Middle, Last) \_\_\_\_\_ Social Security Number \_\_\_\_\_

**E. Prior Coverage/Current Other Coverage - Read the "Notice to Applicant Regarding Replacement of Accident and Sickness Insurance" on back of application.**

- 1.  Yes  No Prior Coverage: Does any person named on this application have qualifying previous coverage(s) for 12 or more months without a lapse of more than 63 days?
- 2.  Yes  No Current Other Coverage: Will you, your spouse or dependent keep other health coverage in addition to this Wellmark, Inc. coverage? If response is "Yes" to 1 and/or 2, the following information must be completed to determine the exclusion period or coordination of benefits provision.

Policyholder Name & Date of Birth	Covered Individual	Effective Date	Term Date	Insurance Company	ID Number
Prior Coverage: _____	<input type="checkbox"/> Self <input type="checkbox"/> Spouse Dependents _____	____/____/____	____/____/____		
Current Other Coverage: _____	<input type="checkbox"/> Self <input type="checkbox"/> Spouse Dependents _____	____/____/____	____/____/____		

**F. Life Insurance Information**

- 1a. Which US Able Life Life Insurance Plan are **you** applying for?  
Ten Year Term Insurance - Renewable, Convertible  
 \$10,000     \$20,000     \$40,000  
 \$60,000     \$80,000     \$100,000
- 1b. Which US Able Life Life Insurance Plan is **your spouse** applying for? (Only if applying for Health Coverage) Ten Year Term Insurance - Renewable, Convertible  
 \$10,000     \$20,000     \$40,000  
 \$60,000     \$80,000     \$100,000

- 2. How do you want to pay your life insurance premiums?  
 **Direct Bill.** If so, on what basis?     Quarterly     Semi-annually     Annually  
 **Automatic Account Withdrawal.** If so, on what basis? (Include a voided check.)  
 Monthly - 4th of the month     Quarterly     Semi-annually     Annually  
From:  Checking or  Savings    **If payor did not sign the application, pre-authorization form is needed. (M-5779)**

3a. Applicant's Beneficiary Designation Primary Beneficiary _____ Relationship _____ Contingent Beneficiary _____ Relationship _____	3b. Spouse's Beneficiary Designation Primary Beneficiary _____ Relationship _____ Contingent Beneficiary _____ Relationship _____
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- 4. Will this life insurance replace any existing life insurance or annuities with this or any other company?  
**Applicant**  Yes  No    **Spouse**  Yes  No    **Agent**  Yes  No

5. Unless otherwise specified, the applicant will be the owner of the life insurance policy. Owner: \_\_\_\_\_

**G. Payment Arrangement**

How do you want to pay for your health premiums and service fees? **Please do not send payment with this application. If paying by automatic withdrawal from checking, attach voided check here.**

Note: All billing periods are based on a calendar year.

- 1. **Direct Bill.** If so, on what basis?     Quarterly     Semi-annually     Annually
- 2. **Account information on file with Wellmark.** (Available only for those with current Wellmark individual coverage.)
- 3. **Automatic Account Withdrawal from applicant's account.**
- 4. **Automatic Account Withdrawal from account other than applicant's.**

If you checked 2, 3, or 4, please complete the following:  
If so, 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 (If you want to have premiums and service fees withdrawn from your savings account, please complete Form M-5779.)

If Direct Bill is **not** selected:  
**As the bank account holder, I authorize Wellmark to make automatic withdrawals from the account indicated on the attached voided check in the amount of the premiums and service fees.**

**Bank Account Holder's Signature** \_\_\_\_\_ **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.**

**H. Agreement and Certification**

I have reviewed the Outline of Coverage. I certify that I have carefully and fully read the Agreement and Certification language and the Notice to Applicant Regarding Replacement of Accident and Sickness Insurance section.  
I have confirmed with all persons named in this application that my signature is binding to secure coverage. I have further confirmed with all persons named in the application 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 application.  
**Please do not send payment with this application. You will be billed or automatic withdrawal will be processed upon approval and enrollment.**

Applicant Signature X \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Legal Guardian Signature (if applicant is a minor) X \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
If guardian, please provide proof of guardianship.

Parent/Legal Guardian Printed Name X \_\_\_\_\_

If applicant is a minor child, please note relationship to applicant X \_\_\_\_\_

Agent Signature X \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Agent No. 6 | 7 | 0 | 0 | 0 | 2 | 3 | 5 |

Agent's Printed Name X Rohan Phillips

I have reviewed the Checklist on the cover page and have completed all necessary sections.

## Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

If this coverage is intended to replace any health coverage currently in force, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy or certificate if issued.

- a. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy or certificate. This could result in denial or delay of a claim for benefits under the new policy or certificate, whereas a similar claim might have been payable under your present policy.
- b. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your current policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
- c. If, after due consideration, 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-health history. Failure to include all vital medical information on an application may provide a basis for Wellmark Blue Cross and Blue Shield of Iowa to deny any future claims and to refund your premium and service fee as though your policy or certificate had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

## Agreement and Certification

I certify that I am legally authorized to apply for coverage for myself and on behalf of all other persons named in this application. I understand that I am applying for coverage as indicated on the reverse side of this application which is underwritten by Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa ("Wellmark"), providing the specified individual health care and dental coverages and USABLE Life providing the life insurance (collective, the "Insurers"). I further understand that coverage applied for will not start until this application and the appropriate premium and service fee payment amount are received and accepted by each Insurer, an effective date of coverage is established, and each Insurer reviews and approves this application and notifies me in writing of approval of coverage.

The coverage effective dates will be as indicated on the reverse side of this application and can be no more than two months past the date I sign this application. Should my application not be approved, my payment will be refunded in full.

The statements and answers set forth in this application (including any related Complete Condition History form) are full, true, and correct. I have consulted with each other person named in this application to confirm that information about them is full, true, and correct. I understand that the Insurers will rely on the completeness and truthfulness of the information given in the statements made in this application (including any related Complete Condition History form) or by telephone or in writing to the Insurers, and that if I have made any fraudulent or material false statements or misrepresentations to the Insurers, or have knowingly or unknowingly failed to disclose any material fact in this application (including any related Complete Condition History form), each Insurer will be entitled to declare coverage applied for void and to refuse allowance of benefits to any person thereunder.

I understand that if this application is approved, the policy will have a 365-day exclusion period for pre-existing conditions unless I or anyone named on this application has had qualifying previous coverage for a total of 365 continuous days with no more than a 63-day lapse of coverage. If the termination date of the qualifying previous coverage is more than 63 days prior to the signature date of this coverage, all members covered under this policy will have a 365-day exclusion period for pre-existing conditions. In the event I have selected Blue Dental coverage on this application, I certify that I have been informed that there will be a six-month exclusion period before benefits are available for basic restorative services including, but not limited to, fillings, extractions, and oral surgery, and a 12-month exclusion period before benefits are available for major restorative services including, but not limited to, endodontics, periodontics, crowns, onlays, and inlays. I understand these dental coverage exclusion periods will not be waived or reduced even if I or any other person named in this application have qualifying existing coverage or qualifying previous coverage.

In the event I have selected HSA coverage on this application, I understand that enrolling in HSA coverage does not guarantee that I am or will be eligible to make contributions to a health savings account or that contributions can be made to a health savings account on my behalf.

I understand this application is subject to medical underwriting. If I or any other person named in this application have certain health conditions, this application may be denied, coverage for certain health condition(s) may be restricted or excluded under this health care coverage, or I may be asked to pay a higher premium under this health care coverage due to certain health condition(s). If health care coverage is denied or restricted, I may be eligible for the Health Insurance Program of Iowa (HIPIowa) offered through the Iowa Comprehensive Health Association (ICHA). A general description including eligibility requirements of the coverage offered through ICHA is available at [www.hipiowa.com](http://www.hipiowa.com). For more information on these plans, please contact your agent.

I understand and agree that the Insurers will continue the medical underwriting process up to the effective date of coverage as entered on this application or assigned by the Insurers, whichever is later. This means that if a condition arises that would have caused an ordinarily 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 prior to the effective date of coverage, regardless of the date I signed the application or the date the application was acted upon by the Insurers, I will so inform the Insurers by sending this information in writing to:

Wellmark Blue Cross and Blue Shield of Iowa  
PO Box 9232, Station 300  
Des Moines, IA 50306-9232

I hereby authorize any health care provider or medically related facility, pharmacy, or pharmacy related facility, the Medical Information Bureau, any pharmaceutical information data source, consumer reporting agency, insurance or reinsurance company or employer having information about me or any other person named in this application to provide all such information as may be requested to the Insurers, their contracted or legal representatives or any medical or pharmaceutical records retrieval service or health support service vendor the Insurers may engage.

This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, lab data, and EKGs. If any law or regulation requires additional authorization for release of medical information or records, I and any other person named in this application will give this authorization. I further agree upon request to furnish the Insurers with information required to administer the requested coverage.

## Agreement and Certification, cont'd

This information may also be disclosed to the Medical Information Bureau or to any medical or pharmaceutical records retrieval service engaged by the Insurers. In addition, this information may be used and disclosed by the Insurers and their vendors for purposes of providing health support services that may be offered from time to time. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by such regulation, all information received by the Insurers pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy or facsimile of this authorization will be as valid as the original.

I understand that this authorization is required in order to, among other things, enable the Insurers to make eligibility, enrollment, benefit determinations, and underwriting and risk rating determinations relating to me and any other person named in this application. If I refuse to sign or I revoke this authorization, the Insurers may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying the Insurers in writing of my desire to revoke. Such revocation must be sent by United States Postal Service certified mail to the Insurers at the address set forth above. Such revocation will not be valid if the Insurers have taken action in reliance on the authorization.

Unless an earlier date is required by law, this authorization expires on the earliest of the following events: denial of my application, declination for enrollment, or, if insured, when I am no longer an insured of Wellmark or USABLE Life.

Premium and service fee payments may be made on a calendar month, calendar quarter, semi-annual calendar year or calendar year basis. For example, a monthly premium and service fee payment 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 you choose to pay your premium and service fee on a quarterly, semi-annual, or annual basis and there is a mid-year increase in the amount of premium(s) and/or service fee(s), the Insurers will send you a notice of the increase in the premium(s) and/or service fee(s). You will have the following responsibility with regard to an increase in premium(s) and service fee(s):

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

I understand that any health condition amendments previously signed and in effect on current individual coverage issued by the Insurers will remain in effect under this new coverage if I am not required by the Insurers to answer health questions on this application.

## Adding and Removing Member Due to an Event

**Adding Members.** The following events allow you to add the person directly affected by the event:

**Appointment as a Legal Guardian** of a child.

**Birth, or Adoption, or Placement for Adoption** of a child.

**Care of a Foster Child** (when placed in your home by an approved agency).

**Dependent** child previously covered under this policy resumes full-time student status.

**Marriage**, which permits addition of the new spouse and the new spouse's children.

For birth, adoption or placement for adoption of a child, you must submit an application within 60 days of the event. If you do not submit an application within 60 days of the event, the child to be added will need to prove insurability.

For other events that allow adding members, you must submit an application to us within 31 days of the date of the event to ensure that the new person will not have to answer health questions to prove insurability. If you do not submit an application within 31 days of the event, the person to be added may need to prove insurability.

**Removing Members.** The following events may require or allow you to remove family members from your coverage:

**Active Military Duty Service** of a member.

**Completion of Full-time Schooling** of a dependent child.

**Death.**

**Dependent Child** who is not a full-time student or permanently disabled reaches age 25.

**Divorce, Annulment or Legal Separation.**

**Marriage** of a dependent child.

## Descriptions of Conditions

**Acne** Any treatment or medication for acne or rosacea.

**AIDS/HIV Positive/ARC** Acquired Immune Deficiency Syndrome or AIDS related complex.

**Alcohol/Substance Abuse** Any use of psychoactive substances including recreational or illegal drugs; alcoholism; any use of alcohol over two drinks per day for women or three drinks per day for men; any treatment or counseling by health care provider, clergy, social worker, other provider, AA or other organization.

**Allergies** Any treatment for allergies (other than drug allergies) by shots, medication or oral drops.

**ALS (Lou Gehrig's Disease)** If ever present.

**Alzheimer's Disease/Dementia** If ever present.

**Arthritis/Rheumatism** Rheumatoid, degenerative or osteoarthritis, bursitis or tendonitis.

**Asthma** Treatment for asthma, including exercise-induced asthma.

**Attention Deficit Disorder/Learning Disorder** Any learning or behavior disorder related to short attention span, impulsiveness, and excessive physical movements that is present or has been treated in the past.

**Back Disorder** Back or neck strains or sprains managed by physical therapy, chiropractic care, massage therapy or other alternative therapies.

**Bladder Disorder** Chronic or recurrent bladder infections, bladder stones, inability to control bladder, retention of urine.

**Blood Disease/Disorder** Low or high blood count, clotting disorder, bleeding disorder, leukemia, all anemias, blood infection or sepsis, Hodgkin's disease, sickle cell anemia, blood protein disorders, hemophilia, blood or lymph cancer, lymphoma.

**Bone Disease/Deformity** Paget's Disease, exostosis, osteoporosis, bone tumors or deformity.

**Bowel Disorder** Diverticulosis, diverticulitis, previous bowel surgery, Hirschsprung's, bowel obstruction, short bowel disorder.

**Breast Disorder** Breast masses, reconstruction, or any other breast disease. Include date of biopsy(es).

**Cancer** Any type of cancer including skin cancer and melanoma.

**Carpal Tunnel Syndrome** Treatment for or symptoms of a disorder related to nerve(s) of the hand, wrist or elbow; symptoms may include numbness, tingling, pain, weakness, and decreased ability to grip.

**Cholesterol or Lipid Disorder** Increased blood levels of lipids that include cholesterol, triglycerides, HDL, and LDL, either under observation or being managed by diet and/or medication.

**Circulatory Disorder** Any condition of the blood vessels or circulation problems.

**Cirrhosis of the Liver** Alcoholic cirrhosis or biliary cirrhosis.

**Colitis** Any type of colitis other than irritable bowel syndrome, ulcerative colitis or Crohn's disease.

**Congenital Disease/Defects** All birth defects such as cleft lip or palate, fused fingers or other defects not mentioned under any other category.

**Coronary Bypass/Coronary Artery Disease/Congestive Heart Failure/Heart Attack** If ever present.

**Crohn's Disease/Regional Ileitis** Ever treated for this condition.

**Cystic Fibrosis** If ever present.

**Diabetes** Includes Type I or II diabetes, insulin resistance, hypoglycemia, glucose intolerance, metabolic syndrome, syndrome X or any blood sugars under observation or being managed by diet and/or medication.

**Disfiguring Scars** Serious scars, such as burns of face or body, scars on the face from an accident or severe acne scars, especially those requiring scar revision or treatment such as injections.

**Ear, Throat, Tonsil Disorders** Ear or throat pain or infections, tubes in ears, enlarged tonsils or adenoids, vocal cord nodules, chronic hoarseness or hearing loss caused by any of the above.

**Eating Disorder** Anorexia, bulimia, binge eating or other disorder characterized by disturbances in eating behavior.

**Emphysema/COPD** Any treatment for or diagnosis of emphysema or Chronic Obstructive Pulmonary Disease (COPD).

**Endometriosis** The presence of abnormal endometrial tissue outside the uterus.

**Epilepsy/Seizure** Any history of seizures. Include date of last seizure.

**Eye Disorder/Disease** Retinal detachment, cataracts, macular degeneration, corneal or lens disorder, chronic eye infection, injury, loss of eye or eye prosthesis, other than visual acuity corrected by lenses.

**Foot Disorder** Any disorder or deformity of the foot including bunions, hammertoes, flat feet, bone spurs, plantar fasciitis, or any use of supports or special foot wear.

**Fractures or Dislocations** Any fracture or dislocation of a bone or joint.

**Gain or Loss of 15 or More Pounds** Any unexplained or unintended weight gain or weight loss.

**Gall Bladder Disorder** History and/or treatment for stones, inflammation or infection; removal of gallstones or gall bladder and other gall bladder attacks.

**Gastric Bypass/Weight Loss Surgery** Any surgical procedure done for the purpose of treating weight, a complication of weight or to result in weight loss.

**Genital Herpes/Syphilis/Sexually Transmitted Diseases** Treatment for genital herpes, HPV, gonorrhea, chlamydia, CMV, syphilis or other venereal disease.

**Headaches, Non-Migraine** Headaches related to tension, stress or sinus disorders that require medical care.

**Hearing Impairment** Hearing loss from any cause, including the use of hearing aids or surgery done to improve hearing.

**Heart Disease or Murmur** Any disease of the heart that has been diagnosed or treated, such as heart attack, coronary artery disease, abnormal rhythm, birth defect, infections or mitral valve prolapse.

**Hernia** Inguinal, Incisional, Ventral, Umbilical, a bulge or protrusion that is present or has been treated.

**High Blood Pressure** Any elevation of blood pressure, either presently being treated by medication or diet or treated in the past.

**HPV/Genital Warts/Human Papilloma Virus** Any history of symptoms or treatment related to this virus, including genital warts.

**Infertility and/or Testing** Problems with conception or fertilization, including artificial means of becoming pregnant.

**Jaw Disorder/TMJ and/or TMD** Any problem with the jaw including temporal mandibular joint disease (TMJ and/or TMD).

**Joint Disorder** Treatment or surgery for any joint disorder including exploratory surgery or joint fusion.

**Kidney Dialysis/Failure** Artificial filtering of the blood due to loss of kidney function.

**Kidney Disorder** Kidney stones, enlarged kidney, injured kidney, chronic infection or nephritis or any other type of kidney disorder.

**Liver Disorder/Hepatitis** Any disorder of the liver including hepatitis, cirrhosis, fatty liver, jaundice or abnormal liver enzyme blood tests.

**Loss of Limb(s)** Any loss of limb (legs, arm, fingers, toes) or use of prosthetic device.

**Lung/Respiratory Disorder** Including chronic bronchitis or any lung disorder.

**Meningitis** Diagnosis or treatment for viral or bacterial spinal meningitis.

**Menstrual Disorder** Irregular periods, excessive bleeding, missed periods, miscarriages, endometriosis, hysterectomy, ovarian or fibroid cysts, pelvic inflammatory disease.

**Mental Retardation** Diagnosis or treatment of mental retardation including Down's Syndrome.

**Migraine Headaches** Migraines or cluster headaches.

**Multiple Sclerosis** If ever present.

**Muscular Dystrophy** If ever present.

**Myasthenia Gravis** If ever present.

**Neurogenic Bladder or Bowel** Lack of bowel or bladder control.

**Neurological Disease/Disorder** Any brain disorder such as abnormal growth in the brain (tumor) or hydrocephaly (water on the brain).

**Organ Transplant Recipient** Replacement of any organ other than cornea.

**Pancreatic Disorders/Acute Pancreatitis** Pancreatic cysts or any other disorder of the pancreas.

**Pancreatitis, Chronic** If ever present.

**Pap Smear, Abnormal** Diagnosis or treatment of abnormal Pap; cervical dysplasia.

**Paralysis** Any loss of movement of a muscle or limb.

**Parkinson's Disease** Chronic neurological condition, if ever present.

**Peripheral Neuropathy** Chronic neurological condition, present or past treatment.

**Peripheral Vascular Disease** Vascular insufficiency, present or past treatment.

**Pregnancy** Confirmed or suspected pregnancy; includes positive home pregnancy test, or missing more than one period, or presence of all or most of the symptoms of pregnancy, whether the pregnancy has been confirmed by a physician or not.

**Prostate Disorder** Infection or enlargement of prostate.

**Psychological/Mental/Nervous Condition** Includes depression, situational depression, anxiety, adjustment reaction, compulsive disorders, panic attacks, chemical imbalance, behavior disorders or any other psychological disorder and/or treatment by any counselor, therapist, psychologist, psychiatrist, social worker, physician or other provider.

**Pulmonary Hypertension** Present primary or secondary, increased pressure in the pulmonary artery.

**Rectal Disorder** Polyps, hemorrhoids, rectal bleeding, fissure, fistula or anal warts.

**Reproductive Organ Disorder** Male or female reproductive organ conditions not disclosed elsewhere, including history of gender reassignment surgery, testicular disorders, congenital disorders, etc.

**Scleroderma** Connective tissue disorder, if ever present.

**Sickle Cell Anemia** Present.

**Sinus Disorder** Multiple or chronic sinus infections or inflammation, previous sinus surgery, sinus polyps, cysts or growths, other sinus disorders.

**Skin Disorder** Diagnosis or treatment for any skin condition including psoriasis, eczema, severe dermatitis, skin pigmentation disorders, birth marks, hemangioma, keratosis, skin cancer, shingles, chronic infection or ulcers of the skin, nail disorders, cysts, tumors, etc.

**Sleep Disorders/Apnea** Disorder that causes disruption of sleep, such as chronic insomnia, sleep apnea, severe snoring, abnormal night-time leg movement disorders, restless leg syndrome.

**Spastic Colon/Irritable Bowel Syndrome** Diagnosis or treatment for irritable bowel, spastic colon, chronic or intermittent constipation or diarrhea, gluten disorders.

**Spinal Disorder** Any condition of the spine or vertebrae, including abnormal curvature, scoliosis, kyphosis, herniated or bulging disc, congenital abnormality, fracture, dislocation, stenosis, spondylosis, prior back or neck surgery.

**Stomach, Esophageal Condition, Ulcer, Hiatal Hernia** Any disorder of the stomach or esophagus such as ulcer, stricture, gastritis, esophageal reflux, other esophagus disorders or hyperacidity.

**Stroke** Any treatment for, or history of a stroke.

**Systemic Lupus Erythematosus** If ever diagnosed with SLE.

**Thyroid Disorder** Enlargement of the thyroid, removal of nodule or lumps, hyperthyroidism (overactive), hypothyroidism (underactive), Graves' disease.

**Tuberculosis/+TB test** Any history, treatment or positive testing of tuberculosis.

**Tumor(s), Cyst(s) or Growth** Any type of lump, tumor, cyst or growth (cancerous or benign).

**Ulcerative Colitis** Diagnosis, treatment or surgery for ulcerative colitis.

**Urinary Tract Disorder** Chronic or recurrent urinary tract infection, stricture of urinary tract, urethral stones or any condition of the urinary tract.

**Varicose Veins** History of vein stripping or varicose veins requiring medical treatment.

**Vein or Artery Disease** Any disease or injury to a blood vessel, including blood clots, thrombophlebitis, embolism, aneurysm, hardening of the arteries, spasms of a blood vessel, TIA, narrowing of a blood vessel (stenosis), poor circulation, AVM, hemangioma.

**Any Other Ailment or Disease** If any disease, ailment or condition that is present that has not been declared, it should be noted.