Wellmark South Dakota

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

Group Employee Application
(For Self-funded and 101+ Markets)

Wellmark Blue Cross and Blue
Shield of South Dakota
PO Box 5023
Sioux Falls, SD 57117-5023
Fax: (515)376-9101

☑ New ☐ Change

A. Employer Information (Completed by Employer)

Group/Billing Unit No.: _____ Department No.: _____

Employer Name: Meade School District 46-1 Phone Number: (605) 347-2523

Address Line 1 (Street Address or Suite#): 1230 Dougas Street

Address Line 2 (PO Box, Street Address): _____

City: Sturgis State: SD ZIP Code: 57785

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 Code: _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____ Ext. _____

E-mail Address (optional): _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retiree ☐ Seasonal Employee Classification: _____

Hire Date: _____/_____/_____

☐ Male ☐ Female Birthdate: _____/_____/_____

Status: ☐ Single ☐ Married ☐ Domestic Partner (Certification of Domestic Partnership Required)

Social Security Number/ Tax Identification Number[1]: _____

[1]Social Security Number (SSN) or Tax Identification Number (TIN) must be provided. Further review may be necessary if an SSN or TIN is not provided.

Health: ☐ Employee ☐ Employee/Spouse or Domestic Partner
☐ Employee/Child(ren) ☐ Employee/Spouse or Domestic Partner/Child(ren)

Health Plan Code: _____ **Deductible Amount:** _____

If you have received or will be issued a Summary of Benefits and Coverage, the SBC includes important information about the Wellmark coverage available to you. In addition, there is important information available to you at Wellmark.com/Inform that addresses a number of topics such as a description of the accessibility and availability of services, including a list of providers participating in the managed care network and a description of the drug formulary provisions in the plan including the process for obtaining a copy of the current formulary and how to request an exception to the formulary. You can also obtain this information by calling 800-774-034.

C. Enrollment Reason or Event

Enrollment Reason: ☐ Open Enrollment ☐ Newly Eligible ☐ Special Enrollment (If you check this option, complete the following)

Special Enrollment Event Reason:

☐ Birth/adoption or placement for adoption
☐ Marriage
☐ Divorce
☐ Foster child placement
☐ Involuntary loss of creditable coverage
☐ Other: _____
☐ Access to a qualified health plan due to a permanent move to South Dakota
☐ Court-ordered coverage
☐ Legal guardianship
☐ Returning from military service

List date of special enrollment event _____/_____/_____ (mm/dd/yyyy) (or last day of coverage)

Employee Name (First, Last)	Social Security Number/Tax Identification Number

D. Members/Enrollees Covered (Please indicate who you are choosing to cover.)

List Name (First, Last) of all others to be covered	Birthdate	Social Security Number / Tax Identification Number[1]	Gender	Full-Time Student?[2]	Disabled?
Spouse or Domestic Partner	/ /		☐ M ☐ F	N/A	☐ Yes
Dependent	/ /		☐ M ☐ F	☐ Yes	☐ Yes
Dependent	/ /		☐ M ☐ F	☐ Yes	☐ Yes
Dependent	/ /		☐ M ☐ F	☐ Yes	☐ Yes
Dependent	/ /		☐ M ☐ F	☐ Yes	☐ Yes

[1]Social Security Number (SSN) or Tax Identification Number (TIN) must be provided for every covered member.
[2]Dependent(s) age 26 and older must be unmarried and either a full-time student or a disabled dependent (disability information request in Section E).

E. Medicare Coverage (Required.)

☐ Yes ☐ No Are you and/or anyone listed in Section D Social Security disabled?

If yes, list names _____

☐ Yes ☐ No Are you and/or anyone listed in Section D enrolled in Medicare?

If yes, complete following as appropriate:

Employee Name (as it appears on Medicare card): _____ Medicare ID (HIC) No.: _____

Effective Date (Part A): _____/_____/_____ Effective Date (Part B): _____/_____/_____

Spouse or Domestic Partner Name (as it appears on Medicare card): _____ Medicare ID (HIC) No.: _____

Effective Date (Part A): _____/_____/_____ Effective Date (Part B): _____/_____/_____

Dependent Name (as it appears on Medicare card): _____ Medicare ID (HIC) No.: _____

Effective Date (Part A): _____/_____/_____ Effective Date (Part B): _____/_____/_____

Employee Name (First, Last)	Social Security Number

F. 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 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 Code: _____

Phone Number (if known): (_____) _____

☐ Yes ☐ No Is there a divorce decree/court order that requires one parent to provide health insurance coverage for any dependent? 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: _____

G. 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.

H. Important Information Regarding Waiver of 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 employer 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 a period of time specified by your employer after the marriage, birth, adoption or placement for adoption. Additionally, you must enroll within a period of time specified by your employer after you lose eligibility for coverage under Medicaid or CHIP or become eligible for Medicaid or CHIP premium assistance.

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 making application for the coverage sponsored by my employer or group sponsor offered by Wellmark of South Dakota, Inc., doing business as Wellmark Blue Cross and Blue Shield of South Dakota, Inc. (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

Employee Name (First, Last)	Social Security Number

I. Authorization and Certification, cont'd

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 the Social Security numbers or tax identification numbers to Wellmark for all members covered under my coverage, I will contact Wellmark by calling the Customer Service number on my ID card. If I do not provide the Social Security numbers or taxpayer identification numbers to Wellmark for this purpose, I may be subject to a $50 penalty per violation imposed by the Internal Revenue Service.

HSA Coverage

If the Health Plan Deductible that I have selected is combined with a Health Savings Account (HSA), I understand that enrolling in HSA 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.

Release of Medical Information

I authorize any health care provider, including but not limited to; surgeon, physician, psychologist, nurse, social worker, or health care facility to release to Wellmark all health and mental health records, including those records protected by Federal or State law relating to AIDS or AIDS related complex, mental health and substance abuse, the past, present, or future treatments or conditions for myself or for my dependents eligible for health care coverage. I understand that I have the right to revoke this authorization in writing at any time by delivering such written notification to the requestor. I understand that a revocation is not effective until received by the requestor. I further understand that any revocation is not effective to the extent that Wellmark or the Provider have relied on it in the use or disclosure of protected health information.

This form does not authorize the redisclosure of medical information. Federal and State regulations do not allow further disclosure of mental health, substance abuse and AIDS/HIV related information. Wellmark maintains the confidentiality of **all** information received and it will not be released to any person or facility.

The protected health information described above may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

I understand that I have the right to refuse to sign this authorization, but that Wellmark will then have the right to condition eligibility determination and enrollment on the receipt of this signed authorization.

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**_____/_____/_____