

A. Application Type

New Hire Late Enrollee Special Enrollee (indicate event & date below) Change (indicate event & date below) Open Enrollment

Event Requiring Contract Change: Marriage Death Divorce Birth/Adoption Other _____ Event Date _____

SSN	Name (Last)	(First)	(MI)
Birth Date	Address (Street)		
	(Apt/Ste #)		
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law	(City)	(State) (Zip) (Phone Number)

Medicare Enrolled? Yes No Soc. Sec. Disabled? Yes No Medicare ID (HIC) No. _____ Part A Part B Part D Eff. Date: _____

B. Coverage Election – Please indicate the coverage you are choosing

Medical(complete if making change): Single Family Plan Type _____

Dental: EE EE/Sp EE/Child(ren) Family

Life AD & D STD LTD

C. Employer – Please complete shaded section for applicant

Company Name		Applicant Occupation	
Company Location	Class	Employer Signature	Date
Hire Date	Eff. Date	Employment Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA	Salary \$ _____ <input type="checkbox"/> Monthly <input type="checkbox"/> Annually
Please indicate if multiple plans are available: <input type="checkbox"/> Health _____ <input type="checkbox"/> Dental _____ <input type="checkbox"/> Vision _____			
<input type="checkbox"/> Employee Life	<input type="checkbox"/> Employee AD&D	<input type="checkbox"/> Employee Opt. Life	<input type="checkbox"/> Dependent Life
<input type="checkbox"/> Spouse Opt. Life	<input type="checkbox"/> Employee STD	<input type="checkbox"/> Employee LTD	
\$ _____	\$ _____	\$ _____	\$ _____

D. Beneficiary Information

	Birth Date	SSN	Relationship	%
Primary Beneficiary				
Contingent Beneficiary				

E. Dependents Enrolled

(First, MI, Last)	Birth Date	Social Security Number	Does dependent reside at home?	Gender	Full Time Student?	Soc. Sec. Disabled?	Medicare Enrolled?
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
Dependent			<input type="checkbox"/> Yes <input type="checkbox"/> No	<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"/> Yes <input type="checkbox"/> No	<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"/> Yes <input type="checkbox"/> No	<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"/> Yes <input type="checkbox"/> No	<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

F. Other Coverage Information If you, your spouse or anyone named on this application will keep other hospital and/or medical coverage in addition to this coverage, please complete the following:

Name (First, MI, Last)	Employer (if applicable)
Insurance Company/HMO Name and Address	Policy No. _____ Contract Type - Medical: <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> 2 person Eff. Date: _____

G. Employee Waiver of Coverage

I, the undersigned, hereby certify that I have been given an opportunity to enroll in the group plan sponsored by my employer. After careful consideration, I have elected not to participate in the following coverage(s). I further understand that, should I decide to participate at a future date, I may have to furnish satisfactory evidence of insurability for myself and, if applicable, any eligible dependents. If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I understand that I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after my other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

<input type="checkbox"/> Employee Health <input type="checkbox"/> Employee Optional Life <input type="checkbox"/> Employee Dental <input type="checkbox"/> Spouse Optional Life <input type="checkbox"/> Employee Vision <input type="checkbox"/> Dependent Health <input type="checkbox"/> Employee Life <input type="checkbox"/> Dependent Dental <input type="checkbox"/> Employee AD&D <input type="checkbox"/> Dependent Vision <input type="checkbox"/> Employee Weekly (STD) <input type="checkbox"/> Dependent Life <input type="checkbox"/> Employee Long Term Disability <input type="checkbox"/> Other _____	Employee Signature _____ Date _____ Witness Signature _____ Date _____
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H. Employee Signature (Required for all available lines of coverage)

I HEREBY REQUEST to be covered and authorize deductions, if any, from my wages for my share of the cost of the benefits for which I am eligible, or may be entitled, under the coverage elected on this form. I hereby represent that any disability indemnity coverage in force and applied for, with respect to myself, is less than 100% of my annual earnings and I further represent that I am not presently disabled and I am performing all the duties of my occupation. (This statement applies to any disability coverage).

Signature _____ Date _____

Agreement 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 applying for coverage as indicated on the reverse side of this application which is underwritten by Wellmark, Inc., doing business as Blue Cross and Blue Shield of Iowa providing the specified health care coverage, and Fort Dearborn Life Insurance Company or Medical Life Insurance Company providing the life insurance (collectively, the "Insurers"). I authorize my employer as my agent, to deduct from my pay or collect from me in advance the premium therefore and remit such sums to the Insurers on my behalf. This authorization is to remain in effect until I or my employer notifies the Insurers to the contrary. I further understand that coverage applied for will not start until after this application and the appropriate premium payment amount are received and accepted by each Insurer and an effective date of coverage is established by the Insurers.

I certify that, after this application was completed, I carefully and fully read it and 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 the Insurers will rely on the completeness and truthfulness given in the statements made in this application, and that if I have made any false statements or misrepresentations, or have failed to disclose or have concealed any material fact, each Insurer will be entitled to declare coverage provided under this application void and to refuse allowance of benefits to any person there under. I authorize any health care provider to release medical records to the Insurers when reasonably related to the coverage for which I have applied. If any law or regulation requires additional authorization for release of medical records, I will give this authorization. I further agree upon request to furnish the Insurers all information required to administer the requested coverage.