Wellmark Blue Cross and Blue Shield of Iowa is an independent licensee of the Blue Cross and Blue Shield Association.

Application for Blue Dental℠ and Avesis Vision & Hearing

Use this form to apply for Blue Dental and/or Avesis Silver Vision and Hearing. These plans are exclusively available for Wellmark MedicareBlue and SeniorBlue Supplement Members, with the exception of SeniorBlue members on Plan J with Drug. The earliest effective date of these plans will be the first of the month following the signature date on this form. The form may also be used to terminate your Medicare supplement plan, your Blue Dental or Avesis Silver Vision & Hearing plans. If you terminate your Medicare supplement plan your Blue Dental and Silver Vision & Hearing plans will also terminate.

REQUESTED EFFECTIVE DATE _____/_____/_____

Instructions: Use a ballpoint pen to complete the form and follow the guidelines listed below:

GUIDELINES				
Complete checked sections if you are using this form to:	**A**	**B**	**C**	**E**
Add Blue Dental plan	✓	✓		✓
Add Silver Vision & Hearing plan	✓	✓		✓
Change Blue Dental plan	✓	✓		✓
Change Silver Vision & Hearing plan	✓	✓		✓
Remove Blue Dental plan	✓		✓	✓
Remove Silver Vision & Hearing plan	✓		✓	✓
Terminate Medicare supplement and optional benefits	✓		✓	✓

A. EXISTING POLICYHOLDER INFORMATION

Existing Policyholder Name (First, Middle, Last)	Wellmark ID	
Physical Address *(Include Street, Bldg Name/No., Apt/Suite#)*	Telephone Number	
City	State	ZIP

If mailing address is NOT the same as the physical address listed above, please complete mailing address information.

Mailing Address *(Include Street, Bldg Name/No., Apt/Suite#)*	PO Box	
City	State	ZIP

B. OPTIONAL BENEFITS

Please select **one** Blue Dental℠ plan. If you do not complete this section of the form, you will remain enrolled on your existing Blue Dental plan. ☐ Blue Dental℠ 100 ☐ Blue Dental℠ 75

Please select **one** Silver Vision & Hearing* plan. If you do not complete this section of the form, you will remain enrolled on your existing Silver Vision & Hearing plan. ☐ Silver Vision & Hearing 100 ☐ Silver Vision & Hearing 130

If you have other health, vision, hearing, or dental coverage currently in force, and you intend to replace that coverage with a Silver Vision & Hearing plan, or a Blue Dental plan, please read the "Notice to Applicant Regarding Replacement of Accident and Sickness Insurance" in Section D.

*Silver Vision & Hearing plans are administered by Avesis, an independent vision insurance company that does not provide Wellmark Blue Cross and Blue Shield products and services. Avesis Silver Vision & Hearing plans are underwritten by Fidelity Security Life Insurance Company, Kansas City, Missouri. Silver Vision & Hearing plans include hearing discount savings plans provided by Amplifon. Amplifon is an independent company that does not provide Wellmark Blue Cross and Blue Shield products or services.

C. TERMINATION (if you terminate your Medicare supplement plan, it will terminate all benefits)

Termination date will be the first of the month following receipt of the request to terminate coverage.

- ☐ Terminate Blue Dental plan
- ☐ Terminate Silver Vision & Hearing plan
- ☐ Terminate both Blue Dental and Silver Vision & Hearing plans
- ☐ Terminate Medicare supplement plan including Blue Dental and/or Silver Vision & Hearing plan(s)

D. NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

If you currently have existing limited scope dental, hearing, or vision insurance, and you intend to lapse or otherwise terminate that existing coverage and replace it with the coverage identified in this application, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions you may presently have may not be fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been paid under your current policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present 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.
3. If after due consideration you still wish to terminate your present policy and replace it with new coverage, be certain to read this application and truthfully and completely answer all questions on the application. Failure to include all material and accurate information, including medical information, may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain all information has been properly recorded.

E. AUTHORIZATION, CERTIFICATION AND SIGNATURE

My signature is considered valid whether I supplied it by telephone or on paper and has the same full force and effect as my written signature.
I understand that by selecting Blue Dental or Avesis Silver Vision & Hearing products, and submitting this form I am electing to purchase an additional insurance product(s). I authorize Wellmark to collect premium for these products in addition to my Medicare supplement plan, including automatic EFT withdrawal from the same bank account which Wellmark has previously received authorization to debit.

Applicant's Signature X _____ Date ____/____/____

OR

Power of Attorney (POA) or Legal Guardian (if applicable):
NOTE: If POA or legal guardian, include a copy of the general POA granting such authority. Do not include a copy of the medical or durable POA.

POA or Legal Guardian Name (please print)_____

POA or Legal Guardian Signature X_____ Date ____/____/____

Agent Name (please print) Dennis H Ober Agent Phone No. (515) 289-2705

Agent Signature Dennis H Ober Date ____/____/____

Agent ID 6 4 8 0 2 0 4 6 Farm Bureau Service Center Number (Bulk Mail Code)_____

Applicant's Farm Bureau Membership Number (if applicable)_____

Wellmark must receive the completed application within 15 days of the Applicant's signature date.

Send completed form to:
Wellmark Blue Cross and Blue Shield of Iowa
Mail Station 3W190
PO Box 14527
Des Moines, IA 50309-3527

OR

Fax to: 515-376-9045

OR

Email to: INDMEMMAIN@wellmark.com

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. 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).

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

주의: 한국어 를 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, नि:शुल्क 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 Deitsch 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).

တၢ်နုးသ့ဉ်ညါ–နမ့ၢ်ကတိၤကညီကျိာ်.ကျိာ်တၢ်မၤစၢၤတၢ်ဖံးတၢ်မၤတဖဉ်.လၢတဘဉ်လာ်ဘူးလဲ.ဆိဉ်လၢနဂီၢ်လီၤ.ဆဲးကျိုးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ၢ်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ၢ်.

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 नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ይሙሉ ያነጋግሩን።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heɓir 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 yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojį' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

09/16 A