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
Fax (515) 376-9101
Email: updatesgroupmembership@
wellmark.com

Failure to fill out this application completely may result in a delay of coverage.

☐ Late Enrollee ☐ Special Enrollee ☐ Change ☐ Open Enrollment Period ☐ Newly Eligible

A. Employer Information (Completed by Employer)

Group/Billing Unit No. 82001-0000 Department Number _____

Employer Name Brandon Valley School District Phone Number (605) 582-2058

Employer Address Line 1 (Street Address or Suite#) 301 S Splitrock Blvd

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

City Brandon State SD ZIP 57005

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 _____

Home Phone Number (_____)_____ Work Phone Number (_____)_____ Ext._____

Email Address (optional) _____

Date of Birth _____/_____/_____ (mm/dd/yyyy) Gender: ☐ Male ☐ Female Status: ☐ Single ☐ Married ☐ Domestic partner

Social Security Number/Tax Identification Number _____

(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.)

Date of Hire (required)_____/_____/_____ (mm/dd/yyyy)

Employment Status: ☐ Full-Time ☐ Part-Time ☐ COBRA ☐ Retiree ☐ Seasonal

Employee Classification _____

Health: ☐ Employee ☐ Employee/spouse or domestic partner

☐ Employee/child(ren) ☐ Employee/spouse or domestic partner/child(ren)

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

As a Wellmark contract holder, you will receive a Summary of Benefits and Coverage (SBC) that outlines important information about your coverage. You can also access Wellmark.com/Inform to help you make the best decisions for you and your family. This site includes important information on your prescription drug coverage, like the accessibility and availability of prescription drugs, how to request a current drug list and the process for requesting an exception to the drug list. You also can find a list of participating providers and facilities, and how to obtain a prior authorization. For more information, or if you have any questions, you can call the Wellmark Customer Service number located on the back of your ID card.

C. Enrollment Reason or Event

Special Enrollment Event Reason:

☐ Birth
☐ Marriage/domestic partner
☐ Divorce
☐ Adoption or placement for adoption
☐ Court-ordered coverage
☐ Open Enrollment
☐ Other _____
☐ Legal guardianship
☐ Foster child placement
☐ Involuntary loss of creditable coverage
☐ Permanent move to South Dakota
☐ 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 If you need to list more than four dependents, please write all necessary information on a separate sheet of paper and attach to this application. Your employer determines eligibility for coverage. Please confirm with your employer that the dependent types listed below are eligible.

List Name (First, MI, Last) of all others to be covered		**Date of Birth** (mm/dd/yyyy)	**Social Security Number/Tax Identification Number**[1]	**Gender**	**FT Student?**[2]	**Disabled?**[2]
☐ Spouse or Domestic Partner		/ /	a. ☐ SSN/TIN ______ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ Male ☐ Female	N/A	☐ Yes
☐ Dependent		/ /	a. ☐ SSN/TIN ______ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ Male ☐ Female	☐ Yes	☐ Yes
☐ Dependent		/ /	a. ☐ SSN/TIN ______ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ Male ☐ Female	☐ Yes	☐ Yes
☐ Dependent		/ /	a. ☐ SSN/TIN ______ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ Male ☐ Female	☐ Yes	☐ Yes
☐ Dependent		/ /	a. ☐ SSN/TIN ______ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ Male ☐ Female	☐ Yes	☐ Yes

[1]The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Your employer will follow up with you to collect this information if you do not complete a., b., or c. for each person listed. Failure to provide the SSN/TIN information may result in a monetary penalty, per violation, assessed to you by the IRS.

[2]If your plan covers dependent(s) age 26 or older, they must be unmarried and either a full-time student or a disabled dependent. Please contact your Wellmark representative for more information.

E. Medicare Coverage (Required)

Are you and/or anyone listed in the Dependent Information section enrolled in Medicare? **(Required if Medicare enrolled, absence of a response will be considered as a response of "No")** ☐ Yes ☐ No

Are you and/or anyone listed in the Dependent Information section Social Security disabled? ☐ Yes ☐ No

If yes, complete as appropriate:

Employee Name (as it appears on Medicare card) ______________________ Medicare ID ______________________

Effective Date (Part A)______/______/______ Effective Date (Part B)______/______/______

Effective Date (Part D)______/______/______

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

E. Medicare Coverage (Required), cont'd

Spouse or Domestic Partner Name (as it appears on Medicare card) _____ Medicare ID _____

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

Effective Date (Part D)_____/_____/_____

Dependent Name (as it appears on Medicare card) _____ Medicare ID _____

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

Effective Date (Part D)_____/_____/_____

F. Other Health Coverage Information (Required)

☐ Yes ☐ No Will you, your spouse, 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 the 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_____

Phone Number (_____)_____

Is there a divorce decree/court order that requires one parent to provide health insurance coverage for any dependent?

☐ Yes ☐ No 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 in Section H of this application.

H. Important Information Regarding Waiver 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 the time specified by your employer after the marriage, birth, adoption, or placement for adoption. Additionally, you must enroll within the 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 benefits documents, or contact your employer.

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

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 completing this application for the coverage sponsored by my employer or group sponsor and 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 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

Wellmark requires social security numbers or other tax identification numbers for federal reporting purposes. If Wellmark does not have Social Security or tax identification numbers for each enrollee, Wellmark or my employer may be unable to report and send information needed to complete federal tax returns. If social security numbers or tax identification numbers are not provided for all individuals covered, Wellmark or my employer may contact the primary policyholder to obtain the information. If I do not provide the social security numbers or tax identification numbers for these purposes, I may be subject to a monetary penalty imposed by the internal revenue service.

HSA Coverage

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

Consent to Contact Me Via Residential Telephone, Cellular Phone, Text and Email Messages

☐ By checking the box and entering my signature on this application, I hereby provide my consent to Wellmark to contact me about Wellmark policy or products and services that may be available to me. Wellmark may provide this information to me using residential telephone, cellular telephone or wireless device, text message or email contact information provided to Wellmark from time to time. If I provide a telephone number for voice calls, I understand that Wellmark may contact me via live or prerecorded calls. I give Wellmark permission to use my personal data (including personally identifiable information) in accordance with Wellmark's privacy policy to determine the types of products and services that may be offered to me. I understand the telephone company or other communications carrier may impose charges for these contacts and that I am not required to give this consent to purchase any goods or services. I understand I may revoke this consent at any time by calling the number located on the back of my Wellmark ID card.

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 authorize the Wellmark agent or agency who is identified with this application or my employer's group application to enter my application information through Wellmark's electronic enrollment process. In the event of any discrepancy between this paper application form and the information entered electronically may be considered the source of records, and I may contact Wellmark to make any changes to my enrollment information. Wellmark authorized agents are required to retain this original paper application for 11 years.

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** _____/_____/_____

If applicant is a minor, please sign below.
Parent/Legal Guardian Printed Name:_____

Parent/Legal Guardian Signature:_____ **Date** _____/_____/_____