



# Application for Individual Health and Life Insurance



PO Box 1650  
Little Rock, Arkansas 72203-1650  
® Registered Mark of USABLE Life Insurance Company

An Independent Licensee of the Blue Cross and Blue Shield Association  
1601 West Madison Street  
Sioux Falls SD 57104

### FOR OFFICE USE ONLY

Effective Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

FB Membership #	FB County #	Group/Billing Unit	County/Region
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### A. Membership Information

New Enrollment (complete all sections)     Change to Existing Coverage

Option 1 – Applicant enters an effective date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Option 2 – Wellmark assigns effective date

Applicant Name (First, Middle, Last)*		Social Security Number	Date of Birth / /
Address (Include Street, PO Box, Building Name/No., Apt. No., City, State, Zip)			Phone ( )
Payor's Billing Information: (Required, if different than address) (Include Name and Address of Payor)			County Name
Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	F/T Student 19 or over? <input type="checkbox"/> Yes
			Disabled? ** <input type="checkbox"/> Yes
			Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
E-mail Address			

\*If this application is for children only, the applicant must be the youngest child.

List all other persons to be covered and their relationship to the primary applicant			Social Security Number	Height	Weight	Gender	F/T Student 19 or over?	Disabled? **
Name (First, MI, Last)	Relationship	Birthdate						
Spouse	Spouse					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Dependent 1						<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Dependent 2						<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Dependent 3						<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Dependent 4						<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

\*\*Is disabled person(s) eligible for Medicare?     Yes     No

In order to complete the underwriting process as soon as possible, Wellmark may need to contact you. Daytime Phone Number or Other Phone Number is required for the applicant and each individual age 18 and older, if different than the applicant's phone numbers.

	Daytime Phone Number	Other Phone Number		Daytime Phone Number	Other Phone Number
Applicant			Dependent 2		
Spouse			Dependent 3		
Dependent 1			Dependent 4		

### B. Enrollment Information

1. The Plan I am applying for is: (Please check one)

<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$1,500 Plus <input type="checkbox"/> \$2,000 Plus <input type="checkbox"/> \$2,500 Plus <input type="checkbox"/> \$5,000 Plus <input type="checkbox"/> \$7,500 Plus	<input type="checkbox"/> \$1,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000	<input type="checkbox"/> HSA-A <input type="checkbox"/> HSA-B
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2.  Yes  No Are you also applying for the Contraceptive Coverage Option? (Only available on Blue Select Plus and Blue Select Basics plans)

Yes  No Are you also applying for the Supplemental Accident Option? (Only available on Blue Select and Blue Select Plus plans)

3.  Yes  No Are you also applying for USABLE Life Insurance? (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 South Dakota products or services. USABLE Life Insurance Company is solely responsible for the life insurance coverage.

For Office Use Only			Date Received
Underwriting Approval	Underwriting	Membership	

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

4. Tobacco Declaration: I, my spouse or my dependent(s) (if included on this application) have used tobacco during the 12 months immediately preceding the date of this application. If yes, please indicate the name and relationship. \_\_\_\_\_  
 Yes     No

5. If this is a change to an existing contract due to an event, check all that apply:     Birth     Death     Marriage     Divorce  
 Medicare Eligible     Adding/Removing Dependent     Other, Specify \_\_\_\_\_  
Date of Event: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_    Name of Affected Party(ies) \_\_\_\_\_

**C. Health Questions**

All questions require a response. Check "All No" only if the questions can be answered No for everyone included on this application. Check "Yes" under the applicant or applicants for whom the condition applies. **If you change your answer, you must initial the change.**

The presence of any of the conditions listed below as well as conditions identified through the review of claims and your previous applications may result in a decision by Wellmark not to offer coverage or to offer coverage with an Amendment to Individual Health Application. If Wellmark does not offer coverage, the State of South Dakota may have coverage options that do not require underwriting for individuals who qualify.

**For any of the numbered/lettered conditions or questions you answer "Yes" to, you must submit Condition History Form(s) OR provide a response at the end of this section. Indicate which you are completing by placing a check in the appropriate box.**

I am submitting Condition History Form(s) with this application.  
 I am completing responses at the end of this section.  
This application cannot be processed without complete information/responses.

**Do not include genetic information in your responses at the end of this section or on any Condition History Forms. That is, do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic disease.**

	All No	Applicant Yes	Spouse Yes	Dep 1 Yes	Dep 2 Yes	Dep 3 Yes	Dep 4 Yes
1. Is anyone listed on this application currently pregnant, or in the last six months had a positive home pregnancy test, a positive physician-directed test, or missed consecutive menstrual cycles? <b>Due Date:</b> _____/_____/_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has anyone listed on this application ever had, received, or been recommended to receive an organ transplant (other than corneal)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does anyone listed on this application have any undiagnosed pain or symptoms? Explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has anyone listed on this application ever had:							
a. Coronary Artery Disease/Heart Valve Disorder/Heart Attack/Heart Failure/Heart Surgery/Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. a Congenital Disorder or Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. a Liver Disorder/Cirrhosis/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. a Stroke/Transient Ischemic Attack (TIA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. AIDS/Tested Positive for HIV/ARC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.**

<b>5. Cardiovascular, Circulatory or Heart Disorders</b>							
a. In the past 10 years had High Blood Pressure or Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. In the past 10 years had an Aneurysm or Artery/Vein Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. In the past 10 years had elevated Cholesterol or Lipid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. In the past 10 years had Varicose Veins or Raynaud's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>6. Blood, Gland, Endocrine, Diabetes, Pituitary or Lymph Node Disorders</b>							
a. In the past 10 years had Blood or Clotting Disorder/Anemia/Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. In the past 10 years had Diabetes/Blood Sugar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. In the past 10 years had any Metabolic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. In the past 2 years had Thyroid Disorder or Goiter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>7. Digestive Disorders</b>							
a. In the past 10 years had Pancreas/Pancreatic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. In the past 10 years had Intestinal/Bowel/Rectal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. In the past 5 years had Stomach or Esophageal Disorder/Ulcer/Gastroesophageal Reflux Disease (GERD)/Hiatal Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. In the past 2 years had Gall Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. In the past 2 years had a Hernia (other than Hiatal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

	All No	Applicant Yes	Spouse Yes	Dep 1 Yes	Dep 2 Yes	Dep 3 Yes	Dep 4 Yes
<b>8. Genitourinary Disorders</b>							
a. In the past 10 years had Kidney/Bladder/Urinary Tract Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. In the past 10 years had Kidney Dialysis/Kidney Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>9. Muscular Skeletal Disorders</b>							
a. In the past 10 years had Bone Fracture/Bone Disorder/Deformity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. In the past 10 years had Muscular Dystrophy/Muscular Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. In the past 10 years had Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. In the past 10 years had Joint Disorder/Joint Replacement/Arthritis/Rheumatism/Bursitis/Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. In the past 10 years had Myasthenia Gravis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. In the past 10 years had Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. In the past 5 years had Jaw Disorder/Temporomandibular Joint – TMJ and/or TMD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. In the past 5 years had a Foot Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. In the past 5 years had Carpal Tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. In the past 5 years had Back/Neck/Spine Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. In the past 2 years had Loss of Limb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>10. Brain or Nerve System Disorders</b>							
a. In the past 10 years had Alzheimer's Disease/Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. In the past 10 years had Epilepsy/Seizures/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. In the past 10 years had Neurological Disorder/Multiple Sclerosis/Parkinson's Disease/Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. In the past 5 years had Motor Neuron Disorder/ALS (Lou Gehrig's Disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. In the past 2 years had Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>11. Respiratory Disorders</b>							
a. In the past 10 years had Cystic Fibrosis/Lung/Pulmonary Disorder/Asthma/COPD/Emphysema/Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. In the past 10 years had Sleep Disorder/Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. In the past 5 years had Allergy/Nasal Disorder/Deviated Septum/Sinusitis/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>12. Female Reproductive Disorders</b>							
a. In the past 10 years had a Breast Disorder/Reconstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. In the past 10 years had Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. In the past 10 years had Infertility Treatment and/or Testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. In the past 5 years had Reproductive Disorder/STD/HPV/Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. In the past 2 years had Abnormal Pap Smear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>13. Male Reproductive Disorders</b>							
a. In the past 10 years had Infertility Treatment and/or Testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. In the past 10 years had a Prostate Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. In the past 5 years had Reproductive Disorder/STD/HPV/Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>14. Eating, Emotional or Mental Health Disorders</b>							
a. In the past 10 years had an Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. In the past 5 years had Psychological/Mental/Nervous/Depression/Anxiety/Emotional Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. In the past 5 years had Alcohol or Drug (including illegal) Abuse/Substance Abuse or Substance Overuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. In the past 2 years had Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

	All No	Applicant Yes	Spouse Yes	Dep 1 Yes	Dep 2 Yes	Dep 3 Yes	Dep 4 Yes
<b>15. Skin Disorders</b>							
a. In the past 10 years had a Skin Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. In the past 5 years had a Keloid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. In the past 2 years had Herpes/Shingles/Post-Herpetic Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. In the past 2 years had Acne/Rosacea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>16. Eyes, Ears, Nose or Throat Disorders</b>							
a. In the past 5 years had Eye Disorder/Visual Disturbance (other than corrective lenses) or Infection /Glaucoma/Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. In the past 2 years had Ear/Nose/Throat/Hearing Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>17. Other</b>							
a. In the past 5 years had Tumor/Cyst or Growth/Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. In the past 1 year had Weight Loss Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>18.</b> In the past 10 years for any condition not listed or previously mentioned on this application, has anyone applying for coverage been seen by or consulted with a health care physician or health care professional; taken prescription or non-prescription medication; or had or been recommended to have surgery, a procedure, diagnostic testing or medical treatment for any other condition not listed or previously mentioned on this application? Do not use this question to provide information or responses for any conditions previously listed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**IF YOU ANSWERED "YES" TO ANY OF THE NUMBERED CONDITIONS OR QUESTIONS AND ARE NOT SUBMITTING CONDITION HISTORY FORM(S), provide a response below. Insert additional pages if necessary. Do not include genetic information in your responses below. That is, do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic disease.**

Condition #	Member affected: <input type="checkbox"/> Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Number: _____	Date of First Symptoms (mm/yy) ____/____	Are you currently receiving treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, date of last symptoms (mm/yy) ____/____
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Condition/treatment information:

Are you currently taking medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list medications:	(Required for #5a) List most recent blood pressure reading: ____/____ Date Taken:(mm/yy) ____/____
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Condition #	Member affected: <input type="checkbox"/> Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Number: _____	Date of First Symptoms (mm/yy) ____/____	Are you currently receiving treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, date of last symptoms (mm/yy) ____/____
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Condition/treatment information:

Are you currently taking medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list medications:	(Required for #5a) List most recent blood pressure reading: ____/____ Date Taken:(mm/yy) ____/____
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Condition #	Member affected: <input type="checkbox"/> Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Number: _____	Date of First Symptoms (mm/yy) ____/____	Are you currently receiving treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, date of last symptoms (mm/yy) ____/____
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Condition/treatment information:

Are you currently taking medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list medications:	(Required for #5a) List most recent blood pressure reading: ____/____ Date Taken:(mm/yy) ____/____
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**D. Payment Information**

1.  Yes  No Will you be paying the premium through a business account? (if yes, answer a and b)
  - a. If submitting a business check, are there any other employees besides you? (This includes full-time and part-time employees)
   
 Yes  No ( If yes, we cannot accept a business check for payment; a personal check must be submitted.)
  - b. Will your premium payments for this coverage be deducted on your federal income tax return other than the special health insurance deduction available to self-employed persons?
   
 Yes  No ( If yes, we cannot accept a business check for payment; a personal check must be submitted.)

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

2. How do you want to pay for your health premiums?  
 Note: All billing periods are based on a calendar year.
- Please do not send payment with this application. If paying by automatic withdrawal from checking, include a voided check.**
- a. **Direct Bill.** If so, on what basis?  Semi-annually  Annually
- b. **Use billing information on file with Wellmark.** (Available only for those with current Wellmark individual coverage.)
- c. **Automatic Account Withdrawal from Applicant's account.**
- d. **Automatic Account Withdrawal from account other than Applicant's.**

If you checked c or d, please complete the following:

On what basis?  Monthly  Quarterly  Semi-annually  Annually

Date of withdrawal:  1st of the month  5th of the month

From:  Checking (Include a voided check.)  Savings (Please complete form M-3506.)

If Direct Bill is **not** selected:  
 As the Bank Account Holder, I hereby authorize Wellmark to make automatic withdrawals from the account shown on the attached voided check in the amount of my periodic premium payment as it may be adjusted from time to time. If the undersigned is not the Applicant, I understand and agree that notices of any premium adjustments when provided to the Applicant shall constitute notice to the undersigned of any such adjustment. I hereby certify that I have read and understand the provisions of the Application Agreement and Certification section below, and specifically the sub-section entitled "Payment Arrangements." This authorization shall supersede and replace any previous authorization given by me for automatic premium withdrawal.

**Bank Account Holder's Signature (if other than Applicant)** \_\_\_\_\_ **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.

**E. Prior Coverage/Current Other Coverage - Read section G "Notice to Applicant Regarding Replacement of Accident and Sickness Insurance"**

1.  Yes  No Prior Coverage: Does any person named on this application have qualifying previous coverage(s) for 11 or more months without a lapse of more than 63 days? (If Prior Coverage is/was provided by a Blue Cross and Blue Shield carrier in another state, indicate the carrier name and state.)
2.  Yes  No Current Other Coverage: Will you, your spouse or dependent keep other health care coverage in addition to this Wellmark of South Dakota, Inc. coverage? (If Other Coverage is provided by a Blue Cross and Blue Shield carrier in another state, indicate the carrier name and state.)
3.  Yes  No If you currently have a Wellmark individual policy, do you intend to replace that coverage with this new policy?
- 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.

Type of Policy	Policyholder Name & Date of Birth	Covered Individual(s)	Effective Date	Term Date	Insurance Company	ID Number
Prior Coverage: <input type="checkbox"/> Group <input type="checkbox"/> COBRA <input type="checkbox"/> Individual			___/___/___	___/___/___		
Prior Coverage: <input type="checkbox"/> Group <input type="checkbox"/> COBRA <input type="checkbox"/> Individual			___/___/___	___/___/___		
Current Other Coverage: <input type="checkbox"/> Group <input type="checkbox"/> COBRA <input type="checkbox"/> Individual			___/___/___	___/___/___		

**F. Life Insurance Information (Only required if purchasing life insurance)**

- |                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1a. Which US Able Life Insurance Plan are <b>you</b> applying for?<br>Ten Year Term Insurance - Renewable, Convertible<br><input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$40,000<br><input type="checkbox"/> \$60,000 <input type="checkbox"/> \$80,000 <input type="checkbox"/> \$100,000 | 1b. Which US Able Life Insurance Plan is <b>your spouse</b> applying for? (Only if applying for Health Coverage) Ten Year Term Insurance - Renewable, Convertible<br><input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$40,000<br><input type="checkbox"/> \$60,000 <input type="checkbox"/> \$80,000 <input type="checkbox"/> \$100,000 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

2. How do you want to pay for your life insurance premiums?
- Direct Bill.** If so, on what basis?  Quarterly  Semi-annually  Annually
- Automatic Account Withdrawal.** (US Able Life withdraws on the 4th of the month.) If so, on what basis?  
 Monthly  Quarterly  Semi-annually  Annually
- Account Type:  Checking (Include a voided check.)  Savings (Please submit pre-printed form from your financial institution)
- If payor did not sign the application, pre-authorization form (M-3506) is needed.**

Applicant Name (First, Middle, Last)	Social Security Number
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**F. Life Insurance Information (Only required if purchasing life insurance), cont'd.**

<b>3a. Applicant's Beneficiary Designation</b> Primary Beneficiary _____ Relationship _____ Contingent Beneficiary _____ Relationship _____	<b>3b. Spouse's Beneficiary Designation</b> Primary Beneficiary _____ Relationship _____ Contingent Beneficiary _____ Relationship _____
<b>4. Will this life insurance replace any existing life insurance or annuities with this or any other company?</b> <div style="display: flex; justify-content: space-around;"> <span><b>Applicant</b>   <input type="checkbox"/> Yes   <input type="checkbox"/> No</span> <span><b>Spouse</b>   <input type="checkbox"/> Yes   <input type="checkbox"/> No</span> <span><b>Agent</b>   <input type="checkbox"/> Yes   <input type="checkbox"/> No</span> </div>	
<b>5. Unless otherwise specified, the applicant will be the owner of the life insurance policy. Owner:</b> _____	

**G. 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 South Dakota to deny any future claims and to refund your premium 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.

**H. Descriptions of Conditions**

**Abnormal Pap Smear**-A pap test is an examination under the microscope of cells taken from the cervix. An abnormal pap test means that some cells were found that do not look normal.

**Acne/Rosacea**-Skin eruptions caused by blocked oil glands that are present now or have been treated in the past. Commonly referred to as pimples, blackheads, whiteheads or cysts. Usually found on face, neck or trunk. Rosacea is red rash of the forehead, chin and nose.

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

**Alcohol or Drug Abuse/Substance Abuse/ Substance Overuse**-Overuse or dependence on alcohol or prescription drugs or any use of psychoactive substances including recreational or illegal drugs that is present now or has been treated in the past.

**Allergy/Nasal Disorder/Deviated Septum/ Sinusitis/Bronchitis**-Any hypersensitivity reaction in the body to a substance, such as animal dander, pollen, dust, feathers and food that is present now or has been treated in the past. Does not include medication allergy. Any disorder or symptom of the nose, sinus, or bronchial tubes which may be acute, chronic, allergic or due to obstruction or injury that is present now or has been treated in the past.

**Alzheimer's Disease/Dementia**-Disorders of memory or orientation; confusion.

**Aneurysm or Artery/Vein Disorder**-Any disorder, weakness, or symptom related to arteries or veins that is present now or has been treated in the past.

**Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD)**-A disorder characterized by hyperactivity, impulsivity or inattention that is present now or has been treated in the past.

**Back/Neck/Spine Disorder**-Back or neck strains or sprains managed by physical therapy, chiropractic care, massage therapy or other alternative therapies. Any condition of the spine or vertebrae, including abnormal curvature, scoliosis, kyphosis (abnormal rounding of the upper spine) herniated or bulging disc, dislocation, stenosis (Spinal stenosis is a narrowing of the spinal canal) or spondylosis (spinal arthritis).

**Blood or Clotting Disorder/Anemia/Bleeding**-Any abnormality of the blood clotting factor or bone marrow's components such as white blood cells, red blood cells and platelets that is present now or has been treated in the past.

**Anemia**: A condition where there is an abnormally low number of red blood cells in the blood.

**Bone Fracture/Bone Disorder/Deformity**-Any disorder, deformity or injury to the skeleton that is present now or has been treated in the past. This includes bone density disorders.

**Breast Disorder/Reconstruction**-Any breast abnormality, breast mass, or surgery of the breast, cosmetic or otherwise, that is present now or has been treated in the past.

**Cancer**-Cancer of any kind that is present now or has been treated in the past. This includes skin cancers (melanoma, basal cell and squamous cell).

**Carpal Tunnel Syndrome**-A specific disorder or symptoms of the fingers, hand, wrist or elbow

caused by nerve entrapment that is present now or has been treated in the past.

Symptoms include numbness, tingling, pain, weakness or decreased ability to grip.

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

**Congenital Disorder or Abnormalities**-Any abnormality present at birth, which was inherited, acquired during the pregnancy or during the process of giving birth that is present now or has been treated in the past.

**Coronary Artery Disease/Heart Valve Disorder/ Heart Attack/Heart Failure/Heart Surgery/ Angioplasty**-Any disorder or symptom that affects the heart that is present now or has been treated in the past.

**Cystic Fibrosis**-A disorder that results in production and secretion of abnormally thick and sticky mucous.

**Diabetes/Blood Sugar Disorder**-A disorder caused by insulin deficiency or insulin resistance that is or was under observation or managed by diet and/or medication. This can be characterized by high or low blood sugar.

**Ear/Nose/Throat/Hearing Disorder**-Any disorder or symptom of any part of the ear, nose or throat that is present now or has been treated in the past.

**Eating Disorder**-Anorexia, bulimia, binge eating or other disorder characterized by disturbances in eating behavior that is present now or has been treated in the past.

**Endometriosis**-The presence of abnormal endometrial tissue outside the uterus that is present now or has been treated in the past.

## H. Descriptions of Conditions, cont'd.

**Epilepsy/Seizure/Convulsions**-Seizures of any kind that are present now or have been treated in the past.

**Eye Disorder/Visual Disturbance (other than corrective lenses) or Infection/Glaucoma/Cataracts**-Any disorder, symptom or injury to the eye that is present now or has been treated in the past.

**Female Reproductive Disorder**-Any disorder or symptom of the female reproductive system that is present now or has been treated in the past. This includes the ovaries, fallopian tubes, uterus, vagina, clitoris, and vulva. This also includes any disorder transmitted by sexual contact.

**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.

**Gall Bladder Disorder**-Any disorder or symptom of the gall bladder that is present now or has been treated in the past.

**Headaches/Migraines**-Pain in the head from any cause that is present now or has been treated in the past.

**Hernia, except Hiatal**-A bulge or protrusion of an organ through the muscle wall that is present now or has been treated in the past.

**Herpes/Shingles/Post-Herpetic Neuralgia**-Any disorder or symptom due to the herpes virus presently being treated or has been treated in the past.

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

**Infertility Treatment and/or Testing – Male or Female**-Problem with conception or fertilization, including artificial means of becoming pregnant that is present now or has been treated in the past.

**Intestinal/Bowel/Rectal Disorder**-Any disorder or symptom of the small, large intestine, rectum or anus that is present now or has been treated in the past.

**Jaw Disorder/Temporomandibular Joint-TMJ/TMD**-Any disorder of the jaw including temporal mandibular joint disease that is present now or has been treated in the past. This includes the use of dental appliances.

**Joint Disorder/Joint Replacement/Arthritis/Rheumatism/Bursitis/Joint Pain**-Any disorder or symptom of the joint, joint lining or other joint structure, presently being treated or has been treated in the past. This includes all forms of arthritis, bursitis, gout, tendonitis, ligament tears and joint replacement.

**Keloid**- Any unusual or abnormal growth of scar tissue on the face or head, an acne scar that is present now or has been treated in the past. History of scar revisions, injections or other treatments.

**Kidney/Bladder/Urinary Tract Disorder**-Any disorder or symptom of the urinary system presently being treated or has been treated in the past. The urinary system includes the kidney, bladder, ureters and urethra.

**Kidney Dialysis/Kidney Failure**-Any disorder of the kidney that results in the need for mechanical filtration (dialysis) or transplantation that is present now or has been treated in the past.

**Liver Disorder/Cirrhosis/Hepatitis**-Any disorder or symptom of the liver that is present now or has been treated in the past.

**Loss of Limb**-Any loss of limb (leg, arm, finger, toe) or use of prosthetic device.

**Lung/Pulmonary Disorder/Asthma/COPD/Emphysema/ Pneumonia**-Any infection, injury, disorder or symptom that diminishes normal lung function that is present now or has been treated in the past.

**Lupus**-A chronic inflammatory disorder of connective tissues that can appear in two forms. Discoid form affects only the skin. Systemic form affects multiple organs as well as the skin.

**Male Reproductive Disorder**-Any disorder or symptom of the male reproductive system that is present now or has been treated in the past. This includes testicles, epididymis, vas deferens, seminal vesicles, ejaculatory duct, prostate or penis. This also includes any disorder transmitted by sexual contact.

**Meningitis**-Infection or inflammation of the membranes surrounding the brain or spinal cord that is present now or has been treated in the past.

**Metabolic Disorder**-Occurs when abnormal chemical reactions in our body disrupt the process the body uses to get or make energy.

**Motor Neuron Disorder/ALS (Lou Gehrig's)**-A degenerative disorder that results in weakness and loss of muscle function.

**Muscular Disorder**-Refers to a condition that may occur intermittently over months or years or for a limited time without recurrence.

**Muscular Dystrophy**-A disorder that causes slow, progressive wasting of muscle tissue.

**Myasthenia Gravis**-A disease affecting the ability of the muscle to contract, leading to progressive weakness.

**Neurological Disorder/Multiple Sclerosis**-Any disorder, symptom or injury to the nervous system (brain, spinal cord, nerves) that is present now or has been treated in the past.

**Pancreas/Pancreatic Disorder**-Any disorder or symptom of the pancreas either present now or has been treated in the past. This does not include diabetes.

**Parkinson's Disease**-A neurological disorder that results in symptoms such as trembling, abnormal of the hands, mask-like face, trouble walking, falls, or swallowing difficulty.

**Pregnancy**-Confirmed or suspected pregnancy confirmed by a physician or not; includes positive home pregnancy test, or missing a period, or presence of all or most of the symptoms of pregnancy.

**Prostate Disorder**-Any disorder or symptom of the prostate that is present now or has been treated in the past. This includes elevated PSA levels.

**Psychological/Mental/Nervous/Depression/Anxiety/ Emotional Disorder**-Any mental, emotional, or behavioral disorder treated by a counselor, therapist, psychologist, psychiatrist, social worker, physician or other provider or managed by prescription medication that is present now or has been treated in the past.

**Scleroderma**-A progressive disorder leading to hardening of the connective tissue of any organ including the skin, heart, esophagus, kidney and lungs.

**Skin Disorder**-Any disorder of the skin or nails that is present now or has been treated in the past.

**Sleep Disorder/Sleep Apnea**-Any disorder that causes an inability to sleep or to remain asleep throughout the night that is present now or has been treated in the past. This includes sleep apnea, insomnia, severe snoring, abnormal night time leg movement and restless leg syndrome.

**STD/HPV/Venereal Disease**-Any disorder acquired by sexual intercourse or genital contact present now or has been treated in the past.

**Stroke/Transient Ischemic Attack (TIA)**-Any disorder or symptom caused by an interruption in the blood supply to parts of the brain that is present now or has been treated in the past. Long term effects will vary by individual.

**Stomach or Esophageal Disorder/Ulcer/Gastroesophageal Reflux Disease (GERD)/Hiatal Hernia**-Any disorder or symptom of the stomach or esophagus that is presently being treated or has been treated in the past.

**Thyroid Disorder or Goiter**-Any symptom or disorder of the thyroid, that is present now or has been treated in the past, including overactive and underactive thyroid.

**Transplant Recipient, except Corneal-Completed or Anticipated**-Organ transplantation that has been completed or is anticipated for bone marrow, single or multiple solid organs. Does not include cornea.

**Tumor/Cyst/Growth/Polyp**-Tumor: a non-cancerous tissue mass that is present now or has been treated in the past.

**Cyst**: a sac containing fluid that is present now or has been treated in the past.

**Polyp**: abnormal growth of tissue projecting from a mucous membrane present now or treated in the past.

**Undiagnosed Pain**-Pain or symptoms which have occurred intermittently over months or years and for which no cause is currently known.

**Varicose Veins or Raynaud's Disease**-Any history of symptomatic varicose veins requiring medical or surgical treatment. Raynaud's Disease - painful spasms of the arteries of the extremities when exposed to cold or stress.

**Weight Loss Surgery**-Any procedure planned or performed, for the purpose of treating excess weight.

**Other Disorder or Treatment Not Previously Defined**-Limited to other disorders, injuries or symptoms not previously defined above that is present now or has been treated in the past.

Applicant Name (First, Middle, Last)	Social Security Number
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## I. Application Agreement and Certification

I certify that I am a bona fide resident of South Dakota and 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 this application which is underwritten by Wellmark of South Dakota, Inc., doing business as Wellmark Blue Cross and Blue Shield of South Dakota (“Wellmark”), providing the specified individual health care coverage 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 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 assigned as indicated on this application. If I requested an effective date, it can be no sooner than the day following the signature date, or no more than 60 days past the signature date. Odd effective dates are allowed for new business, however, if this is a child(ren) only application covering a newborn(s) between age 0-6 months, the earliest effective date is the 1<sup>st</sup> of the month following the signature date. If I did not select an effective date, it will be assigned by Wellmark based upon the approval date. Should my application not be approved, my payment will be refunded in full. If I am making a change to my existing policy with Wellmark, the effective date for most changes is the 1<sup>st</sup> of the month following the signature date.

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.

### Exclusion Periods

I certify that I have been informed of and understand that, if approved for enrollment into an individual Wellmark Blue Cross and Blue Shield of South Dakota plan, the policy issued to me shall be subject to the following:

1. An 11-month exclusion period for all medical conditions that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the 6 months immediately preceding the effective date of coverage and all medical conditions for which medical advice, diagnosis, care or treatment was recommended or received during the 6 months immediately preceding the effective date of this policy.
2. Coverage will not be provided for pregnancy existing on the effective date of coverage.
3. There will be credit given toward satisfying the exclusion periods contained in the policy for which you have applied if you or any family member has had creditable coverage within the last 63 days. The other coverage must have provided substantially similar coverage. All exclusion periods contained in the policy applied for shall commence from the effective date of the policy as assigned by Wellmark Blue Cross and Blue Shield of South Dakota.

### Tobacco User Status

If I answered “No” to the Tobacco Declaration listed on this application, I understand that I am eligible for a special tobacco non-user rate. If this status changes, I must notify the Insurers immediately. The Insurers may require recertification of this status in the future. If the Insurers determine within the initial two years that this status is incorrect, they will retroactively collect historical differences in premiums before claims will be paid, and the tobacco user rate will be applied on the first of the month following receipt of this information.

### Blue Priority HSA

In the event I have selected Blue Priority HSA coverage on this application, I understand that enrolling in Blue Priority 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.

### Medical Underwriting

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).

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 South Dakota  
1601 W Madison Street  
PO Box 5023, Station 353  
Sioux Falls, SD 57117-5023

### Release of Medical Information

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.

Applicant Name (First, Middle, Last)	Social Security Number
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**I. Application 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. I understand that, although federal regulations require that the Insurers inform me 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 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.

**Payment Arrangements**

Premium payments may be made on a calendar month, calendar quarter, semi-annual calendar year or calendar year basis. For example, a monthly premium payment would be for the first day of a month through the last day of such month. A quarterly premium payment would be for any calendar quarterly period, such as January 1 through March 31. A semi-annual premium payment would be for the period of either January 1 through June 30 or July 1 through December 31. An annual premium payment would be for January 1 through December 31 of the applicable year.

In the event I choose to pay my premium on a quarterly, semi-annual, or annual basis and there is a mid-year increase in the amount of premium(s), I will have the following responsibility with regard to an increase in premium(s):

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

I understand and agree that the amount of my periodic premium payment will change as provided in the policy being applied for and from time to time based on changes in my coverage, including but not limited to, changes in benefits, payment obligations (such as deductible, coinsurance and copayments), the number of covered family members, members' ages, changes in tobacco user status, or other factors that require adjustments to the total premium. These changes may occur at times other than an annual or other policy renewal.

I further understand and agree that, if I have elected to authorize automatic premium withdrawals from a deposit account, the automatic withdrawal will change periodically to correspond with the applicable premium. My authorization for automatic premium withdrawals shall include authorization for automatic withdrawal of any changed amount unless I call or provide my bank with written notice not less than three (3) business days before a scheduled withdrawal to stop the payment. If I call my bank to stop payment, I may be required to provide a written request within fourteen (14) days after my call. I will be responsible for any fee assessed by my bank for stop-payment orders that I make.

**Health Condition Amendment for Members Currently Enrolled**

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.

**Acknowledgement**

I have read and understand the Outline of Coverage and each provision of the foregoing Application, including, but not limited to, the sections entitled "Notice to Applicant Regarding Replacement of Accident and Sickness Insurance" and "Application Agreement and Certification." I hereby confirm the authority of Wellmark to make automatic withdrawals from my deposit account as set forth above under "Payment Information," and that this authorization supersedes and replaces any previous authorization given by me with respect to such authority.

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.

**Wellmark must receive this application within 15 days of the date you sign it. Please do not send payment with this application. You will be billed or automatic withdrawal will be processed upon approval and enrollment.**

Applicant Signature  \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

If applicant is a minor, please sign below. (If legal guardian, please provide proof of guardianship.) If this application is for children only, the applicant must be the youngest child.

Parent/Legal Guardian Printed Name & relationship to applicant \_\_\_\_\_

Parent/Legal Guardian Signature X \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Agent Printed Name \_\_\_\_\_ Agent Number 

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Agent Signature X \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_