

Individual Health Plan Contract Change Form

FOR OFFICE USE ONLY	Group/Billing Unit	County/Region	Effective Date ____/____/____
	FB Membership #		FB County #

INSTRUCTIONS

- Please use a ballpoint pen to complete the required information as indicated in Section A.
- If this form is for children only, the policyholder must be the youngest child.
- If the policyholder is under age 18, the signature and relationship of a parent or legal guardian is required. Please provide proof of guardianship.
- If the change being requested is subject to medical underwriting, please complete form M-3510.
- Wellmark must receive this form within 15 days of the date you sign it.
- Please mail the completed form to:
Wellmark Blue Cross and Blue Shield of South Dakota
1601 W Madison Street, Station 338
PO Box 5023
Sioux Falls, SD 57117-5023

A. TYPE OF CHANGE (MARK ALL THAT APPLY)

- Removing policyholder (Complete sections B, C, D, E, F and K)
- Adding/removing spouse or dependent (Complete sections B, C, D, E and K)
- Updating tobacco-use status (Complete sections B, E and K)
- Changing address/phone number (Complete sections B, F and K)
- Decreasing benefits (Complete sections B, G, H and K)
- Adding/removing optional benefits (Complete sections B, H and K)
- Changing billing options (Complete sections B, I, and K)
- Cancellation of entire policy (Complete sections B, J, and K)

B. EXISTING POLICYHOLDER INFORMATION (REQUIRED, PLEASE LIST ON TOP OF EACH PAGE)

Existing Policyholder Name (<i>First, Middle, Last</i>)	Social Security Number
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C. ADDING OR REMOVING POLICYHOLDER, SPOUSE AND/OR DEPENDENTS

<input type="checkbox"/>	Removing Policyholder: <input type="checkbox"/> Active military service (<i>Provide documentation</i>) <input type="checkbox"/> Death <input type="checkbox"/> Medicare Eligible <input type="checkbox"/> Eligible for Employer Group Coverage List date of event: ____/____/____ If eligible for employer group coverage: List carrier name _____ Existing benefits and billing information will remain unless you indicate change(s) on this form.
<input type="checkbox"/>	Adding Spouse and/or Dependent: <input type="checkbox"/> Adoption or Placement for Adoption (<i>Provide documentation</i>) <input type="checkbox"/> Appointment as Legal Guardian (<i>Provide documentation</i>) <input type="checkbox"/> Birth <input type="checkbox"/> Care of a Foster Child (<i>Provide documentation</i>) <input type="checkbox"/> Previously covered dependent resumes full-time student status <input type="checkbox"/> Marriage List date of event: ____/____/____ Existing benefits and billing information will remain unless you indicate change(s) on this form. If adding a spouse or dependent (other than newborn or adoption) an 11-month exclusion period will be applied. Proof of creditable coverage may be attached to determine if the exclusion period can be removed or reduced. If you are currently enrolled in a non-grandfathered plan, or your requested change results in the issuance of a non-grandfathered plan, the pre-existing exclusion period will be waived for individuals under age 19.
<input type="checkbox"/>	Removing Spouse and/or Dependent: <input type="checkbox"/> Active Military Service (<i>Provide documentation</i>) <input type="checkbox"/> Death <input type="checkbox"/> Dependent Child (not a full-time student or permanently disabled) reaches age 26 <input type="checkbox"/> Dependent child completes full-time schooling <input type="checkbox"/> Divorce/Annulment/Legal Separation (<i>Provide documentation</i>) <input type="checkbox"/> Eligible for Employer Group Coverage <input type="checkbox"/> Marriage <input type="checkbox"/> Other, Specify _____ List date of event: ____/____/____ If eligible for employer group coverage: List carrier name _____ List name(s) of member(s) removed: _____ Existing benefits and billing information will remain unless you indicate change(s) on this form.

Existing Policyholder Name (First, Middle, Last)	Social Security Number
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D. MEMBERS TO BE COVERED

List all persons to be covered & their relationship to the policy holder Name (First, MI, Last)	Relationship	Birthdate	Social Security Number	Gender	Full-Time Student?	Disabled?
Policyholder	Self			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
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

E. TOBACCO DECLARATION

Yes No I, my spouse or my dependent(s) (if included on this form) have used tobacco during the 12 months immediately preceding the signature date on this form.

If yes, please indicate name and relationship: _____

F. ADDRESS/PHONE NUMBER

Address (Include Street, PO Box, Building Name/No., Apt No., City, State, Zip)	Phone Number ()
Billing Information (Required, if different than address above) (Include Name and Address of Payor)	County Name

G. PLAN CHANGES

Please change my current grandfathered plan option to a non-grandfathered plan option with the same deductible. Select a first of the month effective date: ___/___/___ . (The earliest an effective date can be is the first of the month following your signature date. If you do not list an effective date, the first of the month following your signature date will be assigned. If you do not answer "Yes" or "No" for each available optional benefit in Section G, Wellmark will assign optional benefits as covered in your existing policy.)

Please decrease the level of my benefits (i.e., increasing the deductible within the same plan option, moving to a plan option that has lesser benefits.) I have selected my new plan by placing a check mark in the box prior to the plan. Select a first of the month effective date: ___/___/___ . (The earliest an effective can be is the first of the month following your signature date. If you do not list an effective date, the first of the month following your signature date will be assigned. If you do not answer "Yes" or "No" for each available optional benefit in Section G, Wellmark will assign optional benefits as covered in your existing policy.)

Current Plan Options

Blue Select® <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	Blue Select® Plus <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	Blue Select® Basics <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000	Blue Priority™ HSA <input type="checkbox"/> HSA-A <input type="checkbox"/> HSA-B
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Products No Longer Offered for New Sales

Blue Select®	Classic Blue®			Basic	Standard	Dakota Benefits Series I	Dakota Benefit Series II	Blue Select® Transitions
<input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5	<input type="checkbox"/> Plan I <input type="checkbox"/> Plan II <input type="checkbox"/> Plan III <input type="checkbox"/> Plan IV	<input type="checkbox"/> Plan V <input type="checkbox"/> Plan VI <input type="checkbox"/> Plan VII	<input type="checkbox"/> Plan A <input type="checkbox"/> Plan B	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> HSA	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> Optional Maternity Rider (not available on \$5000 plan)	<input type="checkbox"/> \$600 <input type="checkbox"/> \$1,200 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$5,000

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H. OPTIONAL BENEFITS

Please indicate "Yes" or "No" for each of the following Wellmark optional benefits. If you do not answer "Yes" or "No" for each optional benefit, Wellmark will assign optional benefits as covered in your existing policy.

Yes No Would you like to have the Contraceptive Coverage Option on your plan? (Available on Blue Select Plus and Blue Select Basics Plans)

Yes No Would you like to have the Supplemental Accident Option on your plan? (Available on Blue Select, Blue Select Plus and Classic Blue I-IV Plans)

I. BILLING 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.)

2. How do you want to pay for health premiums? **If paying by automatic withdrawal from checking, include a voided check.**

Note: All billing periods are based on a calendar year.

a. **Direct Bill.** 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 Policyholder's account.**

d. **Automatic Account Withdrawal from account other than Policyholder'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 Policyholder, I understand and agree that notices of any premium adjustments when provided to the Policyholder shall constitute notice to the undersigned of any such adjustment. I hereby certify that I have read and understand the provisions of the Authorization, Certification and Signature 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 Policyholder) _____ **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.

J. CANCELLATION OF ENTIRE POLICY

I am requesting cancellation of my entire policy effective ____/1/____. I understand Wellmark does not allow cancellation on odd dates and the earliest available cancellation date is the 1st day of the month after Wellmark's receipt of this request. If my policy is set up for Automatic Account Withdrawal, Wellmark must receive this request at least 20 days before my next scheduled withdrawal. To stop payment with less than 20 days notice, I will notify my bank no less than 3 business days before the next scheduled withdrawal. I will be responsible for any associated fees from my bank.

K. AUTHORIZATION, CERTIFICATION AND SIGNATURE

I certify that I am legally authorized to make changes in coverage for myself and on behalf of all other persons named on my current policy and on this form. I have further confirmed with all persons named on my current policy and on this form that my signature is binding to change coverage. If I have made changes in my plan selection, I understand that I am applying for coverage as indicated on this form 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. I further understand that the change requested will not start until this form and the appropriate premium payment amount are received and accepted by Wellmark.

The statements and answers set forth in this form are full, true, and correct. I have consulted with each other person named in this form to confirm that information about them is full, true, and correct. I understand that Wellmark will rely on the completeness and truthfulness of the information given in the statements made in this form or by telephone or in writing to Wellmark, and that if I performed an act, practice or omission that constitutes fraud or I have made an intentional misrepresentation of material fact in this form, Wellmark will be entitled to declare coverage applied for void and to refuse allowance of benefits to any person thereunder.

If I currently have a grandfathered health plan, I understand that making a change to my current benefits could potentially change the grandfathered status of my health care plan. If I lose the grandfathered status of my health care plan, I may be required to incorporate health care reform mandates that are required of the non-grandfathered plans.

Exclusion Period

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.

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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.

If you are currently enrolled in a non-grandfathered plan, or your requested change results in the issuance of a non-grandfathered plan, the pre-existing exclusion period will be waived for individuals under age 19.

Tobacco User Status

If I answered "No" to the Tobacco Declaration listing on this form, I understand that I am eligible for a special tobacco non-user rate. If this status changes, I must notify Wellmark immediately. Wellmark may require recertification of this status in the future. If Wellmark determines within the initial two years that this status is incorrect, it 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.

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 payment would be for any calendar quarterly period, such as January 1 through March 31. A semi-annual payment would be for the period of either January 1 through June 30 or July 1 through December 31. An annual 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), Wellmark will send me a notice of the increase in the 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 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 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 when adding a member(s) to a current grandfathered individual policy issued by Wellmark, any health condition amendments previously signed and in effect on an existing member will remain on the policy. If you are currently enrolled in a non-grandfathered plan, or your requested change results in the issuance of a non-grandfathered plan, any health condition amendments previously signed and in effect will not be applied for individuals under age 19. For individuals over age 19 who are enrolled on a non-grandfathered plan, any health condition amendment previously signed will remain on the policy.

Acknowledgement

I have read and understand the Outline of Coverage and each provision of the foregoing Contract Change Form, including but not limited to, the section entitled "Authorization, Certification and Signature." I hereby confirm the authority of Wellmark to make automatic withdrawals from my deposit account as set forth above under "Payment Arrangement," 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 contract change form that my signature is binding to secure coverage. I have further confirmed with all persons named in this contract change form 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 contract change form.

Existing Policyholder's Signature X _____ Date ____/____/____

New Policyholder's Signature, if applicable X _____ Date ____/____/____

Parent/Legal Guardian Signature (if applicant is a minor) X _____ Date ____/____/____

Parent/Legal Guardian Printed Name and relation to applicant _____

Agent Printed Name _____ Agent No.

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Agent Signature, if applicable X _____ Date ____/____/____