Wellmark Iowa

51+ Group - Enrollment Election

Effective Date* MM/DD/YY
/ /

Group Number*	Sub Group*	Department

Instructions

- To be used by employer groups to add eligible employees to health *and/or* dental insurance.
- This is not to be used for existing contracts to change benefits, change type of contract, add dependents, cancel or update any demographic information.
- * indicates required fields. Form will be returned if any required field is missing or does not contain a valid value. Please reference the Instructions page for explanations of fields and expected values.

Employee Information (1)

Relationship	First Name*	Middle Initial	Last Name*	Date of Birth* MM/DD/YY	Social Security Number*	Gender*	Marital Status*	Medicare ID	Medicare A Date MM/DD/YY	Medicare B Date MM/DD/YY	Provider Number	OBGYN Number	Social Security Disabled	COB	Medical Benefit Selection	Dental Benefit Selection
Subscriber				/ /					/ /	/ /						

Address Line 1*	Address Line 2	City*	State*	ZIP*	Date of Hire* MM/DD/YY
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Spouse - Dependent Information

Relationship*	First Name*	Middle Initial	Last Name*	Date of Birth* MM/DD/YY	Social Security Number*	Gender*	Medicare ID	Medicare A Date MM/DD/YY	Medicare B Date MM/DD/YY	Provider Number	OBGYN Number	Disabled	COB	Medical Benefit Selection	Dental Benefit Selection
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Employee Information (2)

Relationship	First Name*	Middle Initial	Last Name*	Date of Birth* MM/DD/YY	Social Security Number*	Gender*	Marital Status*	Medicare ID	Medicare A Date MM/DD/YY	Medicare B Date MM/DD/YY	Provider Number	OBGYN Number	Social Security Disabled	COB	Medical Benefit Selection	Dental Benefit Selection
Subscriber				/ /					/ /	/ /						

Address Line 1*	Address Line 2	City*	State*	ZIP*	Date of Hire* MM/DD/YY
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Spouse - Dependent Information

Relationship*	First Name*	Middle Initial	Last Name*	Date of Birth* MM/DD/YY	Social Security Number*	Gender*	Medicare ID	Medicare A Date MM/DD/YY	Medicare B Date MM/DD/YY	Provider Number	OBGYN Number	Disabled	COB	Medical Benefit Selection	Dental Benefit Selection
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Employee Information (3)

Relationship	First Name*	Middle Initial	Last Name*	Date of Birth* MM/DD/YY	Social Security Number*	Gender*	Marital Status*	Medicare ID	Medicare A Date MM/DD/YY	Medicare B Date MM/DD/YY	Provider Number	OBGYN Number	Social Security Disabled	COB	Medical Benefit Selection	Dental Benefit Selection
Subscriber				/ /					/ /	/ /						

Address Line 1*	Address Line 2	City*	State*	ZIP*	Date of Hire* MM/DD/YY
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Spouse - Dependent Information

Relationship*	First Name*	Middle Initial	Last Name*	Date of Birth* MM/DD/YY	Social Security Number*	Gender*	Medicare ID	Medicare A Date MM/DD/YY	Medicare B Date MM/DD/YY	Provider Number	OBGYN Number	Disabled	COB	Medical Benefit Selection	Dental Benefit Selection
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Effective Date* MM/DD/YY
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Employee Information (4)

Relationship	First Name*	Middle Initial	Last Name*	Date of Birth* MM/DD/YY	Social Security Number*	Gender*	Marital Status*	Medicare ID	Medicare A Date MM/DD/YY	Medicare B Date MM/DD/YY	Provider Number	OBGYN Number	Social Security Disabled	COB	Medical Benefit Selection	Dental Benefit Selection
Subscriber				/ /					/ /	/ /						

Address Line 1*	Address Line 2	City*	State*	ZIP*	Date of Hire* MM/DD/YY
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Spouse - Dependent Information

Relationship*	First Name*	Middle Initial	Last Name*	Date of Birth* MM/DD/YY	Social Security Number*	Gender*	Medicare ID	Medicare A Date MM/DD/YY	Medicare B Date MM/DD/YY	Provider Number	OBGYN Number	Disabled	COB	Medical Benefit Selection	Dental Benefit Selection
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Effective Date* MM/DD/YY
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Group Number*	Sub Group*	Department

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Employee Information (5)

Relationship	First Name*	Middle Initial	Last Name*	Date of Birth* MM/DD/YY	Social Security Number*	Gender*	Marital Status*	Medicare ID	Medicare A Date MM/DD/YY	Medicare B Date MM/DD/YY	Provider Number	OBGYN Number	Social Security Disabled	COB	Medical Benefit Selection	Dental Benefit Selection
Subscriber				/ /					/ /	/ /						

Address Line 1*	Address Line 2	City*	State*	ZIP*	Date of Hire* MM/DD/YY
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Spouse - Dependent Information

Relationship*	First Name*	Middle Initial	Last Name*	Date of Birth* MM/DD/YY	Social Security Number*	Gender*	Medicare ID	Medicare A Date MM/DD/YY	Medicare B Date MM/DD/YY	Provider Number	OBGYN Number	Disabled	COB	Medical Benefit Selection	Dental Benefit Selection
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Group Number*	Sub Group*	Department

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Employee Information (6)

Relationship	First Name*	Middle Initial	Last Name*	Date of Birth* MM/DD/YY	Social Security Number*	Gender*	Marital Status*	Medicare ID	Medicare A Date MM/DD/YY	Medicare B Date MM/DD/YY	Provider Number	OBGYN Number	Social Security Disabled	COB	Medical Benefit Selection	Dental Benefit Selection
Subscriber				/ /					/ /	/ /						

Address Line 1*	Address Line 2	City*	State*	ZIP*	Date of Hire* MM/DD/YY
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Spouse - Dependent Information

Relationship*	First Name*	Middle Initial	Last Name*	Date of Birth* MM/DD/YY	Social Security Number*	Gender*	Medicare ID	Medicare A Date MM/DD/YY	Medicare B Date MM/DD/YY	Provider Number	OBGYN Number	Disabled	COB	Medical Benefit Selection	Dental Benefit Selection
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Employee Information (7)

Relationship	First Name*	Middle Initial	Last Name*	Date of Birth* MM/DD/YY	Social Security Number*	Gender*	Marital Status*	Medicare ID	Medicare A Date MM/DD/YY	Medicare B Date MM/DD/YY	Provider Number	OBGYN Number	Social Security Disabled	COB	Medical Benefit Selection	Dental Benefit Selection
Subscriber				/ /					/ /	/ /						

Address Line 1*	Address Line 2	City*	State*	ZIP*	Date of Hire* MM/DD/YY
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Spouse - Dependent Information

Relationship*	First Name*	Middle Initial	Last Name*	Date of Birth* MM/DD/YY	Social Security Number*	Gender*	Medicare ID	Medicare A Date MM/DD/YY	Medicare B Date MM/DD/YY	Provider Number	OBGYN Number	Disabled	COB	Medical Benefit Selection	Dental Benefit Selection
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Effective Date* MM/DD/YY
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Employee Information (8)

Relationship	First Name*	Middle Initial	Last Name*	Date of Birth* MM/DD/YY	Social Security Number*	Gender*	Marital Status*	Medicare ID	Medicare A Date MM/DD/YY	Medicare B Date MM/DD/YY	Provider Number	OBGYN Number	Social Security Disabled	COB	Medical Benefit Selection	Dental Benefit Selection
Subscriber				/ /					/ /	/ /						

Address Line 1*	Address Line 2	City*	State*	ZIP*	Date of Hire* MM/DD/YY
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Spouse - Dependent Information

Relationship*	First Name*	Middle Initial	Last Name*	Date of Birth* MM/DD/YY	Social Security Number*	Gender*	Medicare ID	Medicare A Date MM/DD/YY	Medicare B Date MM/DD/YY	Provider Number	OBGYN Number	Disabled	COB	Medical Benefit Selection	Dental Benefit Selection
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Effective Date* MM/DD/YY
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Employee Information (9)

Relationship	First Name*	Middle Initial	Last Name*	Date of Birth* MM/DD/YY	Social Security Number*	Gender*	Marital Status*	Medicare ID	Medicare A Date MM/DD/YY	Medicare B Date MM/DD/YY	Provider Number	OBGYN Number	Social Security Disabled	COB	Medical Benefit Selection	Dental Benefit Selection
Subscriber				/ /					/ /	/ /						

Address Line 1*	Address Line 2	City*	State*	ZIP*	Date of Hire* MM/DD/YY
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Spouse - Dependent Information

Relationship*	First Name*	Middle Initial	Last Name*	Date of Birth* MM/DD/YY	Social Security Number*	Gender*	Medicare ID	Medicare A Date MM/DD/YY	Medicare B Date MM/DD/YY	Provider Number	OBGYN Number	Disabled	COB	Medical Benefit Selection	Dental Benefit Selection
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Employee Information (10)

Relationship	First Name*	Middle Initial	Last Name*	Date of Birth* MM/DD/YY	Social Security Number*	Gender*	Marital Status*	Medicare ID	Medicare A Date MM/DD/YY	Medicare B Date MM/DD/YY	Provider Number	OBGYN Number	Social Security Disabled	COB	Medical Benefit Selection	Dental Benefit Selection
Subscriber				/ /					/ /	/ /						

Address Line 1*	Address Line 2	City*	State*	ZIP*	Date of Hire* MM/DD/YY
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Spouse - Dependent Information

Relationship*	First Name*	Middle Initial	Last Name*	Date of Birth* MM/DD/YY	Social Security Number*	Gender*	Medicare ID	Medicare A Date MM/DD/YY	Medicare B Date MM/DD/YY	Provider Number	OBGYN Number	Disabled	COB	Medical Benefit Selection	Dental Benefit Selection
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Instructions

Required Field - Y = Yes, S = Situational, N = Not Required. Highlighted are those fields that are required by our system to enroll members. In the cases of situational, a field may become required based on the situation. Such as a member on an HMO plan requires a Provider Number or a member over age 65 requires a Medicare ID.

EMPLOYEE INFORMATION		
Field Name	**Required**	**Description**
Effective Date	Y	Date Format MM/DD/YY
Group Number	Y	Group Number - assigned by Wellmark
Sub Group	Y	Section Number - may be tied to classification of employees or benefit
Department	S	Department - used only if needed for billing
Relationship	Y	Subscriber
First Name	Y	First Name
Middle Initial	N	Middle Initial
Last Name	Y	Last Name
Date of Birth	Y	Date Format MM/DD/YY
Employee SSN	Y	Employee SSN*
Gender	Y	Female, Male
Marital Status	Y	Married, Single, Life Partner
Medicare ID	S	Medicare ID
Medicare A Date	S	Medicare Part A Effective Date MM/DD/YY
Medicare B Date	S	Medicare Part B Effective Date MM/DD/YY
Provider Number	S	Provider (PCP) Number (HMO Plan Only)
OB/GYN Number	S	OB/GYN Provider Number (HMO Plan Only)
Social Security Disabled	S	Yes, No
Coordination of Benefits (COB)	S	Yes, No (If yes - fill out N-2318926)
Medical Benefit Selection	S	Medical Benefit Election (Plan 1, HMO, PPO, etc.)
Dental Benefit Selection	S	Dental Benefit Election (Plan 1, HMO, PPO, etc.)
Address Line 1	Y	Address Line 1
Address Line 2	S	Address Line 2
City	Y	City
State	Y	State
ZIP	Y	ZIP
Hire Date	Y	Date Format MM/DD/YY

SPOUSE/DEPENDENT INFORMATION		
Field Name	**Required**	**Description**
Relationship	Y	Wife, Husband, Daughter, Son, Other (Life Partner)
First Name	Y	First Name
Middle Initial	N	Middle Initial
Last Name	Y	Last Name
Date of Birth	Y	Date Format MM/DD/YY
Member SSN	Y	Member SSN
Gender	Y	Female, Male
Medicare ID	S	Medicare ID
Medicare A Date	S	Medicare Part A Effective Date MM/DD/YY
Medicare B Date	S	Medicare Part B Effective Date MM/DD/YY
Provider Number	S	Provider (PCP) Number (HMO Plan Only)
OB/GYN Number	S	OB/GYN Provider Number (HMO Plan Only)
Disabled	S	Yes, No (If Yes and dependent, fill out form N-2312)
Coordination of Benefits (COB)	S	Yes, No (If Yes - fill out form N-2318926)
Medical Benefit Selection	S	Medical Benefit Election (Plan 1, HMO, PPO, etc.)
Dental Benefit Selection	S	Dental Benefit Election (Plan 1, HMO, PPO, etc.)

Account warrants and represents that the information contained herein is true and correct as of the date of submission to Wellmark Blue Cross and Blue Shield (“Wellmark”). As specifically detailed in the Administrative Services Agreement and Group Insurance Policy, the Account is responsible for providing enrollment information, including plan selection, and Wellmark does not accept any responsibility or liability for the accuracy, content, or completeness of the information provided by Account. Account will hold Wellmark harmless from any liability arising out of or in connection with Wellmark’s use of the information provided.

Required Federal Accessibility and Nondiscrimination Notice

Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Wellmark does not exclude people or treat them differently because of their race, color, national origin, age, disability or sex.

Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 5W189, Des Moines, IA 50309-2901, 515-376-4500, TTY 888-781-4262, Fax 515-376-9073, Email CRC@Wellmark.com. You can file a grievance in person, by mail, fax or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone or fax at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

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

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, नि:शुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

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

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

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

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heɓir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

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