

Rohan Phillips

2015 S Ridge Dr
Coralville, IA 52241

128 2nd Ave SW
Cedar Rapids, IA 52402

P. 319 337 8871
TF. 888 337 9746
F. 888 530 7932

Wellmark Application Process

1. Download and print the application. 9 Pages listed below
2. Complete the application in its entirety, answer all appropriate questions.
3. When completing the health questions, please supply all the requested information shown in the boxes below the check boxes.
4. When application is complete, sign in the space provided.
5. Once the application is completed, there are two methods to get your application started.
 - a. Scan the application at 300 dpi into a pdf format and email it to rohan@solutions-insurance.com
 - b. Or, mail it to Solutions Insurance, 2015 S Ridge Dr, Coralville IA 52241

If you have questions at any time through this process, please call Rohan Phillips of Solutions Insurance to get the assistance you need.

Rohan will call you once the application is received to confirm that everything is in order for the application to be sent to Wellmark.

Thank you for choosing to use Solutions Insurance as your Independent Agent. We are here to make sure that you get the best health insurance for your needs.

Sincerely



Rohan Phillips



An Independent Licensee of the Blue Cross and Blue Shield Association

PO Box 9232 • Des Moines, Iowa 50306-9232

Application for Individual Health, Dental & Life Insurance; Application for BlueTransitionsSM



PO Box 1650
Little Rock, Arkansas 72203-1650

FOR OFFICE USE ONLY	
Effective Date	____/____/____
Monthly Premium and Service Fee amount is:	

Select one and, if applicable, provide additional information:

- New Enrollment (Complete entire application.)
 - Increasing Benefits (Complete entire application.)
 - Adding Member to Current Coverage Requiring Medical Underwriting (Complete application except Section B, Enrollment Information.)
- [Existing benefits and current billing information will apply. If you want to decrease benefits, complete Individual Health Plan Contract Change Form, N-5428.]
Note: If you are applying for Blue Transitions coverage only, see Outline of Coverage for eligibility information and complete sections A, B1, B3, B4, D, F, and I.

A. MEMBERSHIP INFORMATION Option 1 – Applicant enters an effective date ____/____/____ Option 2 – Wellmark assigns effective date

Applicant Name (First, Middle, Last) _____ Marital Status: Single Married
 Common Law (Notarized Affidavit Required)

Daytime Phone: () _____ E-mail Address (optional) _____

Mailing Address	Street	Bldg Name/No., Apt. No.	PO Box	City	State	Zip

Payer's Billing Information (if different from Applicant) Payer Name: _____

Payer's Mailing Address	Street	Bldg Name/No., Apt. No.	PO Box	City	State	Zip

	List all persons to be covered			Birthdate	Social Security Number	Height	Weight	Gender	Full-time Student?	Disabled?*	Tobacco User?*
	First	MI	Last								
Applicant								<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse								<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 1								<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 2								<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 3								<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 4								<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

*Is disabled person(s) eligible for Medicare? Yes No
**Answer yes if the person listed has used tobacco during the 12 months immediately preceding the date of this application.

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.

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

B. ENROLLMENT INFORMATION

1. Select product option you are applying for:
- Medically underwritten coverage only** with optional benefits as indicated (complete 2 and 4).
 - OR
 - Blue Transitions coverage only** - subject to eligibility requirements (complete 3 and 4). [Optional benefits *not* available with Blue Transitions.]
 - OR
 - Both medically underwritten and Blue Transitions coverage.** If the medically underwritten plan offer form or Blue Transitions Election form is not returned or if any individuals listed on this application are denied Under 65 coverage and are eligible for Blue Transitions coverage, please enroll the eligible individuals listed in Section A in the Blue Transitions plan selected. (Complete 2, 3 and 4.)

For Office Use Only	Date Received

Applicant Name (First, Middle, Last)	Social Security Number
--------------------------------------	------------------------

B. ENROLLMENT INFORMATION, CONT'D

2a. If applying for **medically underwritten** coverage, select the Wellmark plan you are applying for:

Alliance SelectSM Comprehensive <input type="checkbox"/> 500 <input type="checkbox"/> 1000 <input type="checkbox"/> 1500 <input type="checkbox"/> 3000 <input type="checkbox"/> 4500	Alliance SelectSM Enhanced <input type="checkbox"/> 750 <input type="checkbox"/> 1250 <input type="checkbox"/> 1850 <input type="checkbox"/> 2500 <input type="checkbox"/> 5500 <input type="checkbox"/> 9500	Alliance SelectSM Value <input type="checkbox"/> 2000 <input type="checkbox"/> 5000	Blue Basics <input type="checkbox"/> 3000 <input type="checkbox"/> 5000	Blue Priority HSASM <input type="checkbox"/> 1700A <input type="checkbox"/> 1700B <input type="checkbox"/> 2750A <input type="checkbox"/> 2750B <input type="checkbox"/> 5400A <input type="checkbox"/> Maternity (\$2500 Deductible)
--	---	--	--	---

2b. Please select your Wellmark optional benefits by placing a check mark in the "Yes" or "No" box after each optional benefit. If neither "Yes" or "No" is checked, Wellmark will not enroll applicant and dependents, if applicable, in optional benefit coverage.
 Blue Dental Yes No Supplemental Accident Yes No (not available with Blue Basics and HSA products) Contraceptives Yes No

2c. Please indicate "Yes" or "No" for the USABLE Life Insurance* optional benefit. Yes No If yes, please complete section E.
 If neither "Yes" or "No" is checked, Wellmark will not enroll either the applicant or spouse in the USABLE Life Insurance benefit.
*USABLE Life Insurance Company is an independent life insurance company that does not provide Wellmark Blue Cross and Blue Shield of Iowa products or services. USABLE Life Insurance Company is solely responsible for the life insurance coverage.

3a. If applying for **Blue Transitions** coverage, select the Wellmark plan you are applying for: (Optional benefits are not available with Blue Transitions.)
 Alliance Select Transitions 1500 Alliance Select Transitions 2500 Blue Priority HSA/Alliance Select Transitions 5400

3b. Is anyone listed in Section A eligible for ANY group health plan coverage? Yes No
 If yes, list name(s) _____
 If yes, that person(s) is not eligible for Blue Transitions.

3c. List Wellmark group health plan coverage termination date: ____/____/____

4a. Will your premium and service fee payments for this coverage be deductible on your federal income tax return as a trade or business expense other than the special health insurance deduction available to self-employed persons? Yes No

4b. Will your employer be paying any part of the premium or service fee for this policy either directly or through wage adjustments or other means of reimbursement? Yes No

If you answered yes to either 4a or 4b, check one item below:
 Applicant is owner of a sole proprietor business Employer has only one eligible employee
 Employer is deducting the full premium and service fee Employee is part-time or temporary and not eligible for small employer coverage
 Employer has been denied the opportunity to purchase insurance due to low participation/contribution (attach copy of denial)

C. HEALTH QUESTIONS

All questions require a response. Check "ALL No" only if the questions can be answered No for everyone included on the 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, offer coverage at a rate up and/or issue an Amendment to Individual Health Application. If Wellmark does not offer coverage, the State of Iowa 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? Due Date: ____/____/____	<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.**

5. Cardiovascular, Circulatory or Heart Disorders							
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"/>
6. Blood, Gland, Endocrine, Diabetes, Pituitary or Lymph Node Disorders							
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"/>

Applicant Name (First, Middle, Last)	Social Security Number
--------------------------------------	------------------------

C. HEALTH QUESTIONS, CONT'D							
	All No	Applicant Yes	Spouse Yes	Dep 1 Yes	Dep 2 Yes	Dep 3 Yes	Dep 4 Yes
7. Digestive Disorders							
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"/>
8. Genitourinary Disorders							
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"/>
9. Muscular Skeletal Disorders							
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"/>
10. Brain or Nerve System Disorders							
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"/>
11. Respiratory Disorders							
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"/>
12. Female Reproductive Disorders							
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"/>
13. Male Reproductive Disorders							
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"/>
14. Eating, Emotional or Mental Health Disorders							
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"/>
15. Skin Disorders							
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"/>

Applicant Name (First, Middle, Last)	Social Security Number
--------------------------------------	------------------------

C. HEALTH QUESTIONS, CONT'D

	All No	Applicant Yes	Spouse Yes	Dep 1 Yes	Dep 2 Yes	Dep 3 Yes	Dep 4 Yes
16. Eyes, Ears, Nose or Throat Disorders							
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"/>
17. Others							
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"/>
18. 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) ____/____
-------------	---	--	---

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) ____/____
--	---

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) ____/____
-------------	---	--	---

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) ____/____
--	---

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) ____/____
-------------	---	--	---

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) ____/____
--	---

D. 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 12 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 coverage in addition to this Wellmark 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.

Policyholder Name & Date of Birth	Covered Individual	Effective Date	Term Date	Insurance Company	ID Number
Prior Coverage: _____	<input type="checkbox"/> Self <input type="checkbox"/> Spouse Dependents _____	____/____/____	____/____/____		
Current Other Coverage: _____	<input type="checkbox"/> Self <input type="checkbox"/> Spouse Dependents _____	____/____/____	____/____/____		

Applicant Name (First, Middle, Last)	Social Security Number
--------------------------------------	------------------------

E. LIFE INSURANCE INFORMATION (Available only with medically underwritten coverage)

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

2. How do you want to pay 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.) or Savings **If payer did not sign the application, pre-authorization form is needed. (M-5779)**

<p>3a. Applicant's Beneficiary Designation</p> <p>Primary Beneficiary _____</p> <p>Relationship _____</p> <p>Contingent Beneficiary _____</p> <p>Relationship _____</p>	<p>3b. Spouse's Beneficiary Designation</p> <p>Primary Beneficiary _____</p> <p>Relationship _____</p> <p>Contingent Beneficiary _____</p> <p>Relationship _____</p>
---	--

4. Will this life insurance replace any existing life insurance or annuities with this or any other company?

Applicant Yes No **Spouse** Yes No **Agent** Yes No

5. Unless otherwise specified, the applicant will be the owner of the life insurance policy. Owner: _____

F. PAYMENT INFORMATION

How do you want to pay for your health premiums and service fees? Please do not send payment with this application.

Note: All billing periods are based on a calendar year. If paying by automatic withdrawal from checking, include a voided check.

1. **Direct Bill.** If so, on what basis? Semi-annually Annually

2. **Use billing information on file with Wellmark.** (Available only for those with current Wellmark individual coverage.)

3. **Automatic Account Withdrawal from Applicant's account.**

4. **Automatic Account Withdrawal from account other than Applicant's.**

If you checked 3 or 4, please complete the following:

If so, 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 (If you want to have premiums and service fees withdrawn from your savings account, please complete Form M-5779.)

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 and service fee, if applicable, as they may be adjusted from time to time. If the undersigned is not the Applicant, I understand and agree that notices of any premium and service fee 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.

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 Iowa to deny any future claims and to refund your premium and service fee 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.

Applicant Name (First, Middle, Last)	Social Security Number
--------------------------------------	------------------------

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.

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

H. DESCRIPTIONS OF CONDITIONS, CONT'D

<p>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</p>	<p>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-</p>	<p>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.</p>	<p>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.</p>
--	---	---	--

I. APPLICATION AGREEMENT AND CERTIFICATION

I certify that 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, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa ("Wellmark"), providing the specified individual health care and dental coverages 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 and service fee 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 date will be assigned as indicated on this application. If I requested an effective date, the requested effective date can be no more than 60 days past the date I sign this application. Should my application not be approved, my payment will be refunded in full.

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.

Tobacco User Status

If I answered "No" to the Tobacco Declaration for any person listed on this application, that person is eligible for a special tobacco non-user rate. If this status changes, I must notify the Insurers immediately. The Insurers may require me to recertify this status in the future. If the Insurers determine within the initial two years that this status is incorrect, the Insurers 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.

Exclusion Periods

I understand that if this application is approved, the policy will have a 365-day exclusion period for pre-existing conditions unless I or anyone named on this application has had qualifying previous coverage for a total of 365 continuous days with no more than a 63-day lapse of coverage. If the termination date of the qualifying previous coverage is more than 63 days prior to the signature date of this coverage, all members covered under this policy will have a 365-day exclusion period for pre-existing conditions.

In the event I have selected Blue Dental coverage on this application, I certify that I have been informed that there will be a six-month exclusion period before benefits are available for basic restorative services including, but not limited to, fillings, extractions, and oral surgery, and a 12-month exclusion period before benefits are available for major restorative services including, but not limited to, endodontics, periodontics, crowns, onlays, and inlays. I understand these dental coverage exclusion periods will not be waived or reduced even if I or any other person named in this application have qualifying existing coverage or qualifying previous coverage.

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.

Blue Transitions

I understand that to be eligible for Blue Transitions coverage, I must meet the eligibility requirements listed in the Outline of Coverage. I understand that if I, or any of the other persons named on this application are eligible for or enrolled in group health plan coverage, I (we) are not eligible for Blue Transitions coverage.

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). If health care coverage is denied or restricted, I may be eligible for the Health Insurance Program of Iowa (HIPlowa) offered through the Iowa Comprehensive Health Association (ICHA). A general description including eligibility requirements of the coverage offered through ICHA is available at www.hiapiowa.com. For more information on these plans, please contact your agent.

Applicant Name (First, Middle, Last)	Social Security Number
--------------------------------------	------------------------

I. APPLICATION AGREEMENT AND CERTIFICATION, CONT'D

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 Iowa
 PO Box 9232, Station 300
 Des Moines, IA 50306-9232

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.

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 and service fee payments may be made on a calendar month, calendar quarter, semi-annual calendar year or calendar year basis. For example, a monthly premium and service fee 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 and service fee on a quarterly, semi-annual, or annual basis and there is a mid-year increase in the amount of premium(s) and/or service fee(s), I will have the following responsibility with regard to an increase in premium(s) and service fee(s):

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

I understand and agree that the amount of my periodic premium payment and service fee, if applicable, 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 and service fee, if applicable. 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 and service fee. 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.

Applicant Name (First, Middle, Last)	Social Security Number
--------------------------------------	------------------------

I. APPLICATION AGREEMENT AND CERTIFICATION, CONT'D

Acknowledgment

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.

Please do not send payment with this application. You will be billed or automatic withdrawal will be processed upon approval and enrollment.

Applicant Signature X _____ Date: ____/____/____

If applicant is a minor, please sign below. (If legal guardian, please provide proof of guardianship.)

Parent/Legal Guardian Printed Name _____

Parent/Legal Guardian Signature X _____ Date: ____/____/____

If child(ren) only contract, list natural parent's (s') name(s) _____

Agent's Printed Name Rohan Phillips

Agent Signature X _____ Date: ____/____/____ Agent No. 6 7 0 0 0 2 3 5

Wellmark must receive this application within 15 days of the date the application is signed.

Send completed form to:
Wellmark Blue Cross and Blue Shield of Iowa
PO Box 9232, Station 300
Des Moines, IA 50306-9232
OR
Fax to: 515-248-5309
OR
E-mail to INDMEMMAIN@WELLMARK.COM