An Independent Licensee of the Blue Cross and Blue Shield Association

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

Primary Care Physician (PCP) Selection Form

Use this form to elect your Primary Care Physician.

Shaded area completed by Employer: Group/Billing Unit No.____________ Group Department No.____________ Effective Date______________
Employer Name: ___________________________________ Employer Address: ____

A. Employee Information

Name (First, Last):____ Social Security Number:__________________

Address: ____

City, State, Zip:____

Telephone: ( ) ____

B. PCP Selection

- A primary care provider must be chosen for each family member; females may also select a participating OB/GYN. (If an OB/GYN is **not** selected, your PCP should provide these services.)
- You may change your PCP or OB/GYN by submitting this form or calling the customer service number on your ID card. PCP election changes will be effective the first of the month following receipt of your request.

Full Name (First, Last)	Date of Birth MM-DD-YY	Sex (Check one)	Provider Number	PCP Name (First and Last Name)	PCP Address (Office location where you will receive services)	Are you an established patient?	OB/GYN Provider Number (if enrollee is female)	OB/GYN PCP Name (if enrollee is female)	OB/GYN PCP Address (if enrollee is female)	Are you an established patient?
Self		☐ M ☐ F				☐ Yes ☐ No				☐ Yes ☐ No
Spouse		☐ M ☐ F				☐ Yes ☐ No				☐ Yes ☐ No
Dependent		☐ M ☐ F				☐ Yes ☐ No				☐ Yes ☐ No
Dependent		☐ M ☐ F				☐ Yes ☐ No				☐ Yes ☐ No
Dependent		☐ M ☐ F				☐ Yes ☐ No				☐ Yes ☐ No
Dependent		☐ M ☐ F				☐ Yes ☐ No				☐ Yes ☐ No

Employee Signature____ Date_______/_______/_______

White – Wellmark, Inc. Yellow – Employer Pink – Enrollee

Authorization and Certification

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I understand that I am making application for the coverage sponsored by my employer or group sponsor offered by Wellmark Health Plan of Iowa, Inc. (referenced herein as “Wellmark”) and, when applicable, life and/or disability insurance provided by Fort Dearborn Life Insurance Company (collectively the “Plans”). I authorize my employer, as my agent, to deduct from my pay or collect from me in advance the monthly rates therefore and remit such sums to the Plans on my behalf. This authorization is to remain in effect until the Plans are notified by me or my employer to the contrary. I understand that written notice of rate changes will be furnished by my employer as my agent. I further understand that the coverages applied for will not start until after this application and the appropriate coverage rates are received and accepted by each Plan and an effective date of coverage is established by the Plans.

I certify that, after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that the Plans will rely on the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, the Plans will be entitled to declare the contracts applied for void and to refuse allowance on benefits to any person thereunder.

If I am applying for life and/or disability insurance, I understand that if I am not actively at work on the effective date of my coverage, my life and/or disability insurance will not begin until the day I return to work. I further understand that if I have chosen to waive life and/or disability insurance and I wish to reapply at a later date, I will be required to furnish evidence of insurability satisfactory to the life insurance carrier selected by my employer or group sponsor.

I authorize any health care provider, including but not limited to; surgeon, physician, psychologist, nurse, social worker, or health care facility to release to the Plans all health & mental records, including those records protected by Federal or State law relating to AIDS or AIDS related complex, mental health and substance abuse, the past, present, or future treatments or conditions for myself or for my dependents eligible for health care coverage. This information is being used to carry out pre-enrollment underwriting and is in force until that process is complete, at which time it expires. I understand that I have the right to revoke this authorization in writing at any time by delivering such written notification to the requestor. I understand that a revocation is not effective until received by the requestor. I further understand that any revocation is not effective to the extent that the Plans or Provider have relied on it in the use or disclosure of protected health information.

This form does not authorize the redisclosure of medical information. Federal and State regulations do not allow further disclosure of mental health, substance abuse and AIDS/HIV related information. Wellmark maintains the confidentiality of **all** information received and it will not be released to any person or facility unless the individual is applying for life and/or disability coverage underwritten by Fort Dearborn Life Insurance Company in which case the application, without any further health records or Attending Physician Statements (APS) received, will be released to Fort Dearborn Life Insurance Company.

The protected health information described above may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

I understand that I have the right to refuse to sign this authorization, but that the Plans then have the right to condition eligibility determination and enrollment on the receipt of this signed authorization.