University of Northern Iowa

Human Resource Services

# Retiree Enrollment Form for Health and Dental Insurance

## A. Employee Information (Record legal last and first name as it appears on Social Security Card)

**Name** (Legal Last, Legal First, MI): _____

**Social Security Number*:** _____ **Date of Birth:** _____

**Address:** _____ **Phone Number:** _____

**City, State, Zip:** _____ **Email Address:** _____

## B. Event(s) or Reason(s) for Changing Coverage

**Life Event Note:** You must present Benefits with official documentation within 30 days of the life event.

☐ Retirement ☐ Open Enrollment ☐ Death ☐ Divorce

☐ Marriage ☐ Birth/Adoption ☐ Change of Spouse's or Domestic Partner's Employment

☐ Other (Specify): _____ Date of Event: _____

## C. Benefit and Option Elections

| Benefit Plan | Plan Option |
|---|---|
| **Health** ☐ Self ☐ Spouse/DP ☐ Child(ren) | ☐ UNI PPO (Alliance Select)<br>☐ UNI Blue HMO |
| **Dental** ☐ Self ☐ Spouse/DP ☐ Child(ren) | ☐ UNI Dental 2 |

## D. Members Covered (Please indicate who you are choosing to enroll or cancel from your coverage.)

**Spouse or Domestic Partner:** ☐ Add ☐ Cancel

**Gender:** ☐ Male ☐ Female

**Name** (legal last, legal first, MI): _____

**Date of Birth:** _____ **Social Security Number*:** _____

☐ **UNI Employee** ☐ **Social Security Disabled**

**Dependent 1:** ☐ Add ☐ Cancel

**Gender:** ☐ Male ☐ Female

**Name** (legal last, legal first, MI): _____

**Date of Birth:** _____ **Social Security Number*:** _____

☐ **UNI Employee** ☐ **Full-Time Student** ☐ **Social Security Disabled**

## D. Members Covered (Continued)

**Dependent 2:** ☐ Add ☐ Cancel

**Gender:** ☐ Male ☐ Female

**Name** (legal last, legal first, MI)**:** _____

**Date of Birth:** _____ **Social Security Number*:** _____

☐ **UNI Employee** ☐ **Full-Time Student** ☐ **Social Security Disabled**

* The University of Northern Iowa is required by federal law to report income along with Social Security Numbers (SSNs) for all employees to whom compensation is paid. Employee SSNs are maintained and used by the University for payroll, reporting and benefits purposes, and are reported to federal and state agencies in formats required by law or for benefits purposes. The University will not disclose an employee's SSN without the consent of the employee to anyone outside the University except as mandated by law or required for benefit purposes. Responses to items marked "optional" are options; responses to all other items are required.

## E. Waiver or Cancellation of Enrollment (Please complete if you are waiving or canceling benefits.)

☐ I waive or cancel **Health** coverage for my dependents and myself.

☐ I waive or cancel **Dental** coverage for my dependents and myself.

## F. Medicare Coverage (Required)

**Are you and/or anyone listed in section D enrolled in Medicare?** ☐ Yes ☐ No

*If yes, complete the following:*

**Person 1:** Covered by Medicare (as appears on Medicare card)

_____ **Effective Date** (Part A)**:** _____

**Medicare ID** (HIC) **No.:** _____ **Effective Date** (Part B)**:** _____

**Person 2:** Covered by Medicare (as appears on Medicare card)

_____ **Effective Date** (Part A)**:** _____

**Medicare ID** (HIC) **No.:** _____ **Effective Date** (Part B)**:** _____

## G. Important Information Regarding Waiver of Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependent in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or our dependent's other coverage). However, you must request enrollment within 31 days after you or your dependents other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage or within 60 days of the birth, adoption or placement for adoption. Additionally, you must enroll within 60 days after you lose eligibility for coverage under Medicare or CHIP or become eligible for Medicaid or CHIP premium assistance.

To request special enrollment or obtain more information, contact University of Northern Iowa's Human Resource Services.

**You must read and sign the authorization on Page 3 of this application. ➘**

## H. 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. and/or Delta Dental of Iowa. 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. Iowa Code 509A.13 guarantees health insurance coverage to university retirees up to the age of sixty-five (65). The university is not obligated to provide retiree health insurance to retirees sixty-five or older, or retiree spouses, and can be ended at any time by the employer.

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.

I acknowledge I have received or have been advised and understand I will receive from my employer the Summary of Benefits and Coverage.

The Summary of Benefits and Coverage (SBC) you have received or will be receiving includes important information about the Wellmark coverage available to you. In addition, there is important information available to you at www.wellmark.com/inform that addresses a number of topics such as Wellmark's guidelines on investigational and experimental procedures, the methodologies Wellmark uses to compensate providers, and information on how to access Wellmark's internal claims appeal and external review process. You can also obtain information by calling Wellmark Customer Service at 800-847-1506.

**Release of Medical Information**

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. 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. The Plans maintain the confidentiality of all information received and it will not be released to any person or facility.

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.

**I have read and understand the Important Information Regarding Waiver of Enrollment and Authorization and Certification language on this application and acknowledge receipt of a fully completed copy of this application.**

**Retiree Signature:** _____ **Date Signed:** _____

**This area to be completed by Human Resource Services**

**Life Event Documentation Verified:** Document: _____ Initials: _____ Date _____

☐ Health Group No. _____ ☐ Dental Group No. _____ CVG Effective Date _____

**COBRA Information Sent:** ☐ Yes ☐ No Sent By: _____ Date _____

Wellmark Health Plan of Iowa

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.**

## Designated Personal Doctor Selection Form

*Use this form to elect your Primary Care Physician.*

### A. COBRA Information

Name (First, Last): _____

Telephone: ( ) _____

### B. Designated Personal Doctor (DPD) 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) | Sex (Check one) | Provider Enrollment ID # | DPD Name (First and Last Name) | DPD Address (Office location where you will receive services) | Are you an established patient? | OB/GYN Provider Number (if enrollee is female) | OB/GYN DPD Name (if enrollee is female) | OB/GYN DPD 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 |

Signature _____ Date____/____/____