Attach a Prins Insurance Business Reply Envelope to this application

Wellmark Blue Cross Blue Shield
Short Term Application

1. Fill out the application with as much information that you have available.
2. Call Kristi Nordquist at 332-5300 if you have any questions while you are filling it out.
3. When you have it completed, stop by the office or send the application and your check payable to "Wellmark Blue Cross Blue Shield" for the premium choice shown on the quote:

Kristi Nordquist
Prins Insurance, Inc.
5517 N Cliff Ave
Sioux Falls, SD 57104

Note: If you choose to pay monthly, you have to use electronic automatic account withdrawal. There is a $10.00 charge for each monthly payment.

- Please include phone numbers where we can call you or where an underwriter from Wellmark Blue Cross Blue Shield can call if there are any questions.

An Independent Licensee of the Blue Cross and Blue Shield Association

1601 West Madison • Sioux Falls, SD 57104

Application For Short Term Major Medical Expense Policy

FB Membership No. and FB County No., if applicable	Group/Billing Unit	County #

ELIGIBILITY CHECKLIST: If you answer "yes" to any of the following eligibility questions, a policy cannot be issued.

1. Are you, or any person to be covered:
   a. a resident of a state other than South Dakota . . . . . ☐ No ☐ Yes
   b. younger than 15 days old? . . . . . ☐ No ☐ Yes
   c. seeking coverage while traveling outside the U.S.? . . . . . ☐ No ☐ Yes
2. Will you, or any person to be covered, become eligible for Medicare or Medicaid during the policy term? . . . . . ☐ No ☐ Yes
3. Within the last five years, have you or any person to be covered:
   a. been treated, diagnosed, or been advised to seek treatment for: heart or circulatory system disorder including heart disorder or disease; stroke; diabetes, cancer or tumor; alcohol abuse; drug abuse or chemical dependency? . ☐ No ☐ Yes
   b. been treated, diagnosed or been advised to seek treatment for an immune system disorder including acquired immune deficiency (AIDS) or AIDS Related Complex (ARC) and/or tested HIV positive? . . . . . ☐ No ☐ Yes
   c. been declined for health insurance due to health reasons? . . . . . ☐ No ☐ Yes
4. Are you, your spouse or any dependent now pregnant? . . . . . ☐ No ☐ Yes
5. Do you or anyone else listed on this application currently have hospital and/or medical coverage through Wellmark Blue Cross and Blue Shield of South Dakota, or any other company, that will not terminate prior to the effective date? . . . . . ☐ No ☐ Yes

MEMBERSHIP INFORMATION

NAME OF PRIMARY APPLICANT (FIRST, MIDDLE, LAST)	SOCIAL SECURITY NO.		BIRTHDATE / /
ADDRESS (INCLUDE STREET, BUILDING NAME/NO., APT. NO., CITY, STATE, ZIP)	HOME PHONE ( )	SEX ☐ M ☐ F	MARITAL STATUS ☐ SINGLE ☐ MARRIED

List all other individuals to be covered, in addition to primary applicant.

First	MI	Last	Relationship	BIRTHDATE M / D / Y	SOCIAL SECURITY NO.	SEX	FT STUDENT AGE 19 TO 23
				/ /		☐ M ☐ F	☐ Yes
				/ /		☐ M ☐ F	☐ Yes
				/ /		☐ M ☐ F	☐ Yes
				/ /		☐ M ☐ F	☐ Yes
				/ /		☐ M ☐ F	☐ Yes

POLICY TYPE INFORMATION

THIS REQUEST FOR COVERAGE IS FOR:	POLICY TERM NOT TO EXCEED 6 MONTHS	DEDUCTIBLE/OUT-OF-POCKET MAXIMUM
☐ SINGLE	☐ 1 MO. ☐ 3 MO. ☐ 5 MO.	☐ $ 250 / $1,000
☐ TWO-PERSON	☐ 2 MO. ☐ 4 MO. ☐ 6 MO.	☐ $ 500 / $1,500
☐ FAMILY	☐ OTHER ____________	☐ $ 1,000 / $3,000

PAYMENT INFORMATION

☐ CHECK ENCLOSED FOR ENTIRE POLICY TERM

☐ MONTHLY AUTOMATIC ACCOUNT WITHDRAWAL* (available only for policy durations of 3 months or more)

*ADD $10.00 PER MONTH TO THE MONTHLY PREMIUM AMOUNT, INCLUDING THE FIRST MONTH, IF USING THIS METHOD. FOR MONTHLY AUTOMATIC BANK PAYMENTS, YOUR POLICY MUST END ON THE FIRST DAY OF THE MONTH AND THE POLICY TERM CANNOT EXCEED 6 MONTHS OF COVERAGE.

DO YOU WANT IT DEDUCTED FROM: ☐ SAVINGS ☐ CHECKING--ATTACH A VOIDED CHECK

IF SOMEONE OTHER THAN PRIMARY APPLICANT IS PAYING THROUGH AUTOMATIC BANK WITHDRAWAL, PLEASE COMPLETE FORM M-3506 (U) AUTHORIZATION FOR AUTOMATIC WITHDRAWAL.

PREMIUM SUBMITTED	EFFECTIVE DATE*	TERMINATION DATE	☐ 1ST ISSUANCE
$			☐ 2ND ISSUANCE

*The effective date cannot be prior to or the same date as the date you sign this application.

Primary Applicant Name (First, Middle, Last)	Social Security Number	Group/Billing Unit No.	Effective Date

AGREEMENT AND CERTIFICATION

I certify that I am legally authorized to apply for coverage for myself and for all other persons named in this application. I understand that I am making application for the coverage offered by Wellmark of South Dakota, Inc., doing business as Wellmark Blue Cross and Blue Shield of South Dakota(“Wellmark”), and that coverage will not start on the requested effective date until after this application and the premium submitted are received and accepted by Wellmark and the requested effective date is approved by Wellmark.

I certify that, after this application was completed, I carefully and fully read it, that the statement 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 Wellmark will rely upon 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 have concealed any material fact, Wellmark will be entitled to declare the health care policy void and to refuse allowance of benefits to any person thereunder.

I understand that the coverage applied for will not pay benefits for any expense incurred for any preexisting condition. I understand that this is not a continuation of any previous coverage, including any prior Wellmark Blue Cross and Blue Shield of South Dakota Short Term Major Medical policy.

I acknowledge that this plan may cause me to lose HIPAA portability rights (guarantees of eligibility for insurance in certain circumstances) in South Dakota.

I acknowledge receipt of a copy of this application, an outline of coverage, and a benefits policy.

APPLICANT SIGNATURE ____________________ DATE ____________

AGENT SIGNATURE ____________________ DATE ____________

Richard A Applequist

PRINT AGENT NAME

AGENT NO.

5	7	4	0	0	4	5	2

Why Consider Automatic Account Withdrawal?

No checks to write, no stamps to buy, no trips to the mailbox. Just tell us the checking or savings account from which you want your premium payment withdrawn, and your payments are made to us automatically—just as though you had written us a check, minus the time and bother.

It's Convenient

You choose when you want to pay—monthly, quarterly, semi-annually or annually. Your premium will be paid on the first of the month when a payment is due.

It's Sure

Your payment always arrives on time—even when you're away on business or pleasure, or just too busy to write and mail checks. The statement from your financial institution shows the withdrawal and serves as proof of payment.

It's Easy

Just fill out and sign the attached authorization form, attach a **voided check** or pre-printed **deposit slip** for the account, and return them to us with your next payment.

It's Free

In fact, you save the cost of postage, and so do we.

If you are not interested in automatic account withdrawal, but are interested in changing your current billing option, please call our Customer Service Department at

1-800-831-4818

Authorization for Automatic Account Withdrawal

(Please return this authorization form with your payment)

YES, I authorize Wellmark Blue Cross and Blue Shield of South Dakota/USAble Life to make automatic withdrawals from the account shown on the enclosed ***voided check*** or ***deposit slip*** in the amount of my premiums.

Insured's Name ____

Insured's Identification Number ____

Payment Frequency (check one): Monthly _____ Quarterly _____ Semi-Annually _____ Annually _____

Do you prefer (check one)?

1st of the month _____ 5th of the month _____ (USAble Life withdraws on the 4th of the month)

What type of account is this? _____ Checking _____ Savings

Account Signature(s)*

____

____

Date ______________________________________

*If Power of Attorney or Legal Guardian, please include a copy of those documents.

Wellmark Blue Cross and Blue Shield of South Dakota must receive your signed authorization at least 20 days before your next payment is due in order to start the first automatic withdrawal. If your account balance is not sufficient to pay your premium, we will notify you of the amount due to continue your coverage.

Blue Cross and Blue Shield of South Dakota