

A. Application Type

Application type options: New Hire, Late Enrollee, Special Enrollee, Change, Open Enrollment. Includes fields for SSN, Name (Last, First, MI), Birth Date, Address (Street, Apt/Ste #), Gender, Marital Status, City, State, Zip, Phone Number, Medicare Enrolled, Soc. Sec. Disabled, Medicare ID (HIC) No., Part A/B/D, Eff. Date.

B. Coverage Election - Please indicate the coverage you are choosing

Coverage election options for Medical, Dental, and Vision. Includes checkboxes for Self, Spouse, Child(ren) and Plan Type options: Life, AD & D, STD, LTD.

C. Employer - Please complete shaded section for applicant

Employer information section including Company Name, Applicant Occupation, Company Location, Class, Employer Signature, Date, Hire Date, Eff. Date, Employment Status, Salary, and various plan options like Employee Life, AD&D, Opt. Life, etc.

D. Beneficiary Information

Beneficiary information table with columns for Name, Birth Date, SSN, Relationship, and %.

E. Dependents Enrolled (First, MI, Last)

Table for dependent enrollment with columns for Name, Birth Date, Social Security Number, Gender, Full-Time Student?, Soc. Sec. Disabled?, and Medicare Enrolled?.

F. Other Coverage Information

Other coverage information section including Name (First, MI, Last), Employer (if applicable), and Insurance Company/HMO Name and Address.

G. Prior Coverage Information

Prior coverage information section including Name of Covered Person, Employer (if applicable), and Insurance Company/HMO Name and Address.

H. Employee Waiver of Coverage

Waiver of coverage section with a large text block explaining the waiver and a list of coverage options to be waived. Includes fields for Employee Signature, Date, Witness Signature, and Date.

I. Employee Signature (Required for all available lines of coverage)

I HEREBY REQUEST to be covered and authorize deductions, if any, from my wages for my share of the cost of the benefits for which I am eligible, or may be entitled, under the coverage elected on this form.

Signature

Date

#### Agreement 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 applying for coverage as indicated on the reverse side of this application which is underwritten by Wellmark, Inc., doing business as Blue Cross and Blue Shield of Iowa providing the specified health care coverage, and Fort Dearborn Life Insurance Company or Medical Life Insurance Company providing the life insurance (collectively, the "Insurers"). I authorize my employer as my agent, to deduct from my pay or collect from me in advance the premium therefore and remit such sums to the Insurers on my behalf. This authorization is to remain in effect until I or my employer notifies the Insurers to the contrary. I further understand that coverage applied for will not start until after this application and the appropriate premium payment amount are received and accepted by each Insurer and an effective date of coverage is established by the Insurers.

I certify that, after this application was completed, I carefully and fully read it and 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 Insurers will rely on the completeness and truthfulness given in the statements made in this application, and that if I have made any false statements or misrepresentations, or have failed to disclose or have concealed any material fact, each Insurer will be entitled to declare coverage provided under this application void and to refuse allowance of benefits to any person there under. I authorize any health care provider to release medical records to the Insurers when reasonably related to the coverage for which I have applied. If any law or regulation requires additional authorization for release of medical records, I will give this authorization. I further agree upon request to furnish the Insurers all information required to administer the requested coverage.