WellFirst Health®
provided by SSM Health Plan

2022 Illinois Marketplace Individual & Family Policy Application Worksheet

Agent/Office Use Only	
Agency Name/Code	PCP Location
Writing Agent's Name	Effective Date

Please complete this entire application in ink.
The application process requires you to complete all of the following:

- **Individual Policy Application Worksheet, Applicant Information, Terms and Conditions, and Form A**

- **Select One of the Payment Methods for First Month's Premium**
  - ❑ **Personal Check *(required with application)***
  - ❑ **Automatic Transfer of Funds *(Form B required)***

Copay Plus & Classic Plan Options	Deductible Individual / Family	Coinsurance	Max Out-of-Pocket Individual / Family
Gold Copay Plus 1500X ❑	$1,500 / $3,000	20%	$5,100 / $10,200
Silver Copay Plus 4800X ❑	$4,800 / $9,600	30%	$8,700 / $17,400
Bronze Copay Plus 8650X ❑	$8,650 / $17,300	0%	$8,650 / $17,300
Silver Classic 5000X ❑	$5,000 / $10,000	20%	$8,700 / $17,400

Copay Plus & Classic Prescription Drug Benefits – Gold & Silver *offer $15 Generics, $50 Preferred Brand, 50% Non-Preferred Brand, 50% Specialty*
Bronze *offers $15 Generics & no charge after deductible on all other tiers*

Value Copay Plan Options	Deductible Individual / Family	Coinsurance	Max Out-of-Pocket Individual / Family
Gold Value Copay 3700X ❑	$3,700 / $7,400	0%	$3,700 / $7,400
Silver Value Copay 5000X ❑	$5,000 / $10,000	30%	$8,700 / $17,400
Bronze Value Copay 8650X ❑	$8,650 / $17,300	0%	$8,650 / $17,300

Value Copay Prescription Drug Benefits – Gold & Silver *offer $15 Generics, 50% Preferred Brand, 50% Non-Preferred Brand, 50% Specialty*
Bronze *offers no charge after deductible on all tiers*

HSA Eligible & Catastrophic Plan Options	Deductible Individual / Family	Coinsurance	Max Out-of-Pocket Individual / Family
Silver HSA-E 4500X ❑	$4,500 / $9,000	20%	$7,000 / $14,000
Bronze HSA-E 6950X ❑	$6,950 / $13,900	0%	$6,950 / $13,900
Catastrophic Safety Net** ❑	$8,700 / $17,400	0%	$8,700 / $17,400

HSA Eligible & Catastrophic Prescription Drug Benefits – *Policy coinsurance after deductible on all tiers*

** If selecting the Catastrophic Safety Net plan and you are age 30 or older, please list your Federal Hardship Exemption Certificate Number (ECN) _____

Requested Effective Date

m m / d d / y y y y

The Affordable Care Act offers specific effective dates for each enrollment situation. Please visit wellfirsthealth.com for more information.

Please indicate the reason for submitting this application:

❑ Open Enrollment

❑ Special Enrollment* (qualifying event and date required)

Qualifying Event _____

Event Date m m / d d / y y y y *May require documentation

WellFirst Health — Provided by SSM Health Plan • PO Box 56099 • Madison, WI 53705-7674
866-514-4194 • TTY: 711 • wellfirsthealth.com

Applicant Information

Step 1 **Tell us about yourself.**

(We'll need one adult, age 18 or older, to be the contact person for your application and billing information.)

1) First name, Middle name, Last name, & Suffix

2) Home address | 3) Apartment or suite number

4) City | 5) State | 6) ZIP code | 7) County

8) Mailing address *(if different from home address)* | 9) Apartment or suite number

10) City | 11) State | 12) ZIP code | 13) County

14) Phone Number ( ) -

15) Other Phone Number ( ) -

16) Do you want to get information about this application by email? ☐ Yes ☐ No

Email address _____

17) Preferred spoken or written language *(if not English)*

18) Do you need health coverage for yourself?
☐ Yes. **If yes**, answer all the questions below.
☐ No. **If no**, skip to Question 23.

19) Social Security number

___ ___ ___ - ___ ___ - ___ ___ ___ ___

20) Sex ☐ Male ☐ Female

21) Date of birth *(mm/dd/yyyy)* _____ / _____ / _____

22) Do you use tobacco? *(required if age 21 or older)* ☐ Yes ☐ No

Tobacco use is defined as use of tobacco on average of four or more times per week in the past six months, unless for ceremonial or religious purposes.

23) Is there an authorized representative for someone **other than your minor dependent(s)** listed on this application? *(requires legal documentation as proof)*
☐ Yes. **If yes**, please enter name and select a relationship below:
Authorized Representative _____
☐ Guardian or other court-appointed role
☐ Power of attorney
☐ Other (please specify) _____

24) Does anyone applying for coverage currently have health insurance?
☐ Yes. **If yes**, please fill in your insurance information below:
Current Insurance Provider _____
Member ID Number(s) _____

Special Enrollment *– If you are applying for coverage under the Special Enrollment rule* ***AND*** *you answered YES to Question 24,* ***you must enter applicant information for every individual who will be covered under the policy.***

Now, tell us who else needs health coverage.

NEED HELP WITH YOUR APPLICATION? Visit wellfirsthealth.com or call us at **866-514-4194**. If you need help in a language other than English, call **866-514-4194** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY: **711**.

Step 2 **Tell us about anyone else who needs health coverage.**

(If you have more people to include, make a copy of this page and attach.)

Person 2

1) First name, Middle name, Last name, & Suffix		2) Relationship to you
3) Social Security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___	4) Date of birth *(mm/dd/yyyy)* _____ / _____ / _____	5) Sex ☐ Male ☐ Female

6) Does Person 2 live at the same address as you? ☐ Yes ☐ No **If no,** list address below.

7) Does Person 2 use tobacco? *(required if age 21 or older)* ☐ Yes ☐ No

Tobacco use is defined as use of tobacco on average of four or more times per week in the past six months, unless for ceremonial or religious purposes.

Person 3

1) First name, Middle name, Last name, & Suffix		2) Relationship to you
3) Social Security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___	4) Date of birth *(mm/dd/yyyy)* _____ / _____ / _____	5) Sex ☐ Male ☐ Female

6) Does Person 3 live at the same address as you? ☐ Yes ☐ No **If no,** list address below.

7) Does Person 3 use tobacco? *(required if age 21 or older)* ☐ Yes ☐ No

Tobacco use is defined as use of tobacco on average of four or more times per week in the past six months, unless for ceremonial or religious purposes.

Person 4

1) First name, Middle name, Last name, & Suffix		2) Relationship to you
3) Social Security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___	4) Date of birth *(mm/dd/yyyy)* _____ / _____ / _____	5) Sex ☐ Male ☐ Female

6) Does Person 4 live at the same address as you? ☐ Yes ☐ No **If no,** list address below.

7) Does Person 4 use tobacco? *(required if age 21 or older)* ☐ Yes ☐ No

Tobacco use is defined as use of tobacco on average of four or more times per week in the past six months, unless for ceremonial or religious purposes.

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Step 3 **Read the Terms and Conditions and sign the Application**

Application Terms and Conditions

1. By signing this Application, I understand and agree that: (a) All statements and answers I have given are complete and true to the best of my knowledge and belief; (b) the health coverage I hereby apply for will be effective only when SSM Health Plan, as the health plan offering WellFirst Health (WellFirst), approves this Application. Evidence of such approval will be issuance of ID card(s) and policy. The effective date will be the date shown on the I.D. card issued; (c) the Social Security numbers I have provided may be used for I.D. purposes; and (d) if my or my dependents' information has changed from what is indicated on the Application prior to the effective date of coverage, I will notify SSM Health Plan of the change immediately.
2. I further understand that my information on this form will only be used to determine eligibility for health coverage and will be kept private as required by law.
3. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an Application for health coverage is guilty of a crime and may be subject to fines and/or imprisonment or subject to other penalties under law. I further understand that, in the event of fraud or intentional misrepresentation, claims may be denied in whole, or in part, and coverage may be rescinded.
4. I also understand that a medical provider, medical facility or pharmacy benefit manager that provides treatment or service to me, my spouse and dependents covered under this Application, may generally disclose information relevant to that treatment/service to the health plan or its representatives after my/our enrollment begins. Such information may be used for the purposes of claims adjudication, quality assurance, quality improvement, care management and other activities according to the health plan's Notice of Privacy of Practices, which is available at wellfirsthealth.com.
5. All statements and answers in this Application are representations made by me on behalf of myself and other persons named in the Application, if any, to induce the issuance of the policy applied for. The contents of this Application are to be solely relied upon by the health plan.
6. I, the undersigned, on behalf of myself and my dependents, if any, named in this Application, agree to cooperate in providing the health plan with any information needed to process this Application.
7. This Application, when approved, and any endorsement, forms, amendment or rider thereto, will be made part of the policy that is issued.
8. I understand that an insurance agent or broker cannot modify, waive or change in any way this Application, any requirement imposed by the health plan, nor bind coverage or guarantee approval of this Application. No person, except an officer of the health plan, is authorized to vary or modify a policy or contract. I further understand and agree that the health plan, its directors, officers, employees, and agents shall not be liable for any injury, damage or expense (including attorney's fees) that I or any of my dependents suffer as a result of any improper advice, action or omission on the part of any health care provider.

Signature of Applicant	Date (mm/dd/yyyy)
Signature of Spouse/Domestic Partner	Date (mm/dd/yyyy)
Signature(s) of Adult Children Age 18 or Older	Date (mm/dd/yyyy)

Notice To Applicant Regarding Replacement of Accident/Sickness Insurance (Form A)

This Policy provides ten (10) days within which you can decide, at no cost to you, whether you desire to keep this Policy.

If you intend to lapse or otherwise terminate your present policy and replace it with a Policy issued by SSM Health Plan, the following facts should be considered before you make this change:

1. You may have health conditions covered under your present policy that may not be covered under the new Policy. This could result in the denial of future benefit claims relating to these health conditions under the new Policy.

2. Questions in the Application for the new Policy must be answered truthfully and completely; otherwise, the validity of the new Policy, and the payment of any benefits thereunder, may be voided.

3. The new Policy will be issued at a higher age than that used for issuance of your present policy; therefore, the cost of the new Policy, depending upon the benefits, may be higher than you are paying for your present policy.

4. The renewal provisions of the new Policy should be reviewed, as they may differ from your present policy.

It may be to your advantage to secure the advice of your present insurer, or its agent, regarding the proposed replacement of your present policy. You should be certain that you understand all the relevant factors involved in replacing your present coverage.

The above "Notice to Applicant" was delivered to me on _____
Date (mm/dd/yyyy)

_____
Signature of Applicant

Authorization for Automatic Transfer of Funds (Form B)

WellFirst Health
provided by SSM Health Plan

WellFirst Health – Provided by SSM Health Plan offers an easy way to make monthly premium payments, called the **Direct Premium Payment Program**. This service allows us to automatically transfer funds from your checking or savings account on a monthly basis to pay your monthly premiums. This program ensures your monthly premiums will be paid timely even if you are traveling and there is no cost to you for this service.

To participate, simply sign this authorization and attach a voided check that shows the bank and account number. Please be sure to fill in your financial institution name, routing number and account number below. We will take care of the rest!

The Direct Premium Payment Program will generally start on the 23rd of the month following acceptance of your application. You will receive a letter prior to the first transfer notifying you of the amount that will be transferred from your account and when the first transfer will occur. Thereafter, your monthly premium will be transferred from your account on the 23rd of each month or the business day following. Any transactions that are not possible due to insufficient funds will be your responsibility.

If you have any questions, please contact the Customer Care Center at (866) 514-4194, TTY users dial 711, Monday through Thursday 7:30 a.m. to 5:00 p.m. and Friday 8:00 a.m. to 4:30 p.m. Form B can be submitted along with your application or mailed direct to Enrollment Department, PO Box 56099, Madison, WI 53705.

By the Authorized Bank Account Holder signature below, I authorize SSM Health Plan, as the health plan offering WellFirst, to instruct my financial institution to deduct my premium payments from the account designated below. I authorize the financial institution to debit the amount of my premium from my designated account. This authorization is to remain in full force and in effect until SSM Health Plan has received written notification from the individual member of their termination in such time and in such manner as to afford SSM Health Plan and the financial institution a reasonable opportunity to act on it.

_____ _____

Name of Account Holder (please print) Name of Financial Institution

Routing number | | | | | | | | | | Type ☐ Checking ☐ Savings

Account number | | | | | | | | | | | | | | | | | |

_____ _____

Signature of Authorized Bank Account Holder Date (mm/dd/yyyy)