An Independent Licensee of the Blue Cross and Blue Shield Association

Submission Cover Page

Medicare Supplement Coverage

Applicant Name: ____
(Print) First Middle Last

Applicant ID: ______________________
(Example: IAXXXXXXX)

Plan Name: ____

Please attach the following items to this page if applicable.

☐ Authorization for Automatic Account Withdrawal form (to be completed by Payor)

Your application for health insurance has been submitted to us electronically, so you don't need to send another copy to us.

List all plicies you have sold to applicant in the last 5 years including those no longer in force.

Company	Policy Number	Type of Policy	In Force (Y/N)

My signature below certifies I am legally authorized to apply for coverage for all persons named in this application and I agree to comply with those terms outlined in the Agreement and Certification section of my online application.

______________________ Authorized Signature	___/___/___ Date	______________________ Relationship to Applicant* (Please Print)
______________________ Authorized Signature	___/___/___ Date	______________________ Relationship to Applicant* (Please Print)
______________________ Authorized Signature	___/___/___ Date	______________________ Relationship to Applicant* (Please Print)
______________________ Agent Signature	___/___/___ Date	______________________ Agent Number

*Relationship: Self, Spouse, Parent, Step Parent, Foster Parent, Legal Guardian, Power of Attorney, Oldest Dependent, Other.

Send this cover page and the materials listed above. to:

Wellmark Blue Cross and Blue Shield
Station 3W190
PO Box 14527
Des Moines, IA 50306-3527
Email: INDMEMMAIN@Wellmark.com
Fax: 515-376-9045

Note: If this is the only documentation you are sending to us, please fax this page to the number above.