



An Independent Licensee of the Blue Cross and Blue Shield Association

# Submission Cover Page

## Short Term Major Medical Coverage

Applicant Name: \_\_\_\_\_  
(Print)                      First    Middle    Last

Applicant ID: \_\_\_\_\_  
(Example: IAXXXXXXX)

Plan Name: \_\_\_\_\_

Please attach the following items to this page if applicable.

- Health Insurance Payment: \$\_\_\_\_\_ payable to Wellmark Blue Cross and Blue Shield
- Authorization for Automatic Account Withdrawal form (to be completed by Payor)
- Affidavit Common Law Marriages form

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

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. If this application is for dependent children only, dependents over age 18 must sign below. If any person listed on this application is under age 18, a parent/legal guardian must also sign below.

_____	_____/_____/_____	_____
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: [INDMEMAIN@Wellmark.com](mailto:INDMEMAIN@Wellmark.com)  
Fax: 515-376-9045