

Use this form to apply for Avesis Silver Vision and Hearing. This plan is exclusively available for Wellmark Medicare Supplement members. The earliest effective date of this plan will be the first of the month following the signature date on this form. The form may also be used to terminate your Medicare supplement plan and/or Avesis Silver Vision & Hearing plan. If you terminate your Medicare supplement plan your Silver Vision & Hearing plan will also terminate.

REQUESTED EFFECTIVE DATE ____/____/____

Instructions: Use a ballpoint pen to complete the form and follow the guidelines listed below:

GUIDELINES

Complete checked sections if you are using this form to:	A	B	C	D
Add Silver Vision & Hearing plan	✓	✓		✓
Change Silver Vision & Hearing plan	✓	✓		✓
Remove Silver Vision & Hearing plan	✓		✓	✓
Terminate Medicare supplement and optional benefits	✓		✓	✓

A. EXISTING POLICYHOLDER INFORMATION

Existing Policyholder Name (<i>First, Middle, Last</i>)	Wellmark ID		
Physical Address (<i>Include Street, Bldg Name/No., Apt/Suite#</i>)	Telephone Number		
City	State	ZIP	

If mailing address is NOT the same as the physical address listed above, please complete mailing address information.

Address Line 1 (*Include Street, Bldg Name/No., Apt/Suite#, PO Box*)

Address Line 2 (*City, State, ZIP*)

B. OPTIONAL BENEFITS

Please select one **Avesis Silver Vision & Hearing plan**. For current MedicareBlue Supplement members, with an existing Silver Vision & Hearing plan, if you do not complete this section of the application, you will remain enrolled on your current Silver Vision & Hearing plan.

☐ Silver Vision & Hearing 100 ☐ Silver Vision & Hearing 130

Silver Vision & Hearing plans are administered by Avesis, an independent vision insurance company that does not provide Wellmark Blue Cross and Blue Shield products and services. Avesis Silver Vision & Hearing plans are underwritten by Fidelity Security Life Insurance Company, Kansas City, Missouri. Silver Vision & Hearing plans include hearing discount savings plans provided by Amplifon. Amplifon is an independent company that does not provide Wellmark Blue Cross and Blue Shield products or services.

C. TERMINATION (if you terminate your Medicare supplement plan, it will terminate all benefits)

Termination date will be the first of the month following receipt of the request to terminate coverage.

- ☐ Terminate Silver Vision & Hearing plan
☐ Terminate Medicare supplement plan and Silver Vision & Hearing plan

D. AUTHORIZATION, CERTIFICATION AND SIGNATURE

My signature is considered valid whether I supplied it by telephone or on paper and has the same full force and effect as my written signature.

Consent to Contact Me Via Residential Telephone, Cellular Phone, Text and Email Messages

☐ By checking this box and entering my signature on this application, I hereby provide my consent to Wellmark to contact me about my Wellmark policy or products and services that may be available to me. Wellmark may provide this information to me using residential telephone, cellular telephone or wireless device, text message or email contact information provided to Wellmark from time to time. If I provide a telephone number for voice calls, I understand that Wellmark may contact me via live or prerecorded calls. I give Wellmark permission to use my personal data (including personally identifiable information) in accordance with Wellmark's privacy policy to determine the types of products and services that may be offered to me. I understand the telephone company or other communications carrier may impose charges for these contacts and that I am not required to give this consent to purchase any goods or services. I understand I may revoke this consent at any time by contacting Wellmark Customer Service.

I understand that by selecting Avesis Silver Vision & Hearing products, and submitting this form I am electing to purchase an additional insurance product. I authorize Wellmark to collect premium for these products in addition to my Medicare supplement plan. If I am set up on auto pay, these additional premiums would be automatically withdrawn from my bank account that is currently on file and which Wellmark has previously received authorization to debit.

I certify that I am a legal resident of South Dakota.

Applicant's Signature X _____ Date ____/____/____

OR

Power of Attorney (POA) or Legal Guardian (if applicable):

NOTE: If POA or legal guardian, include a copy of the general POA granting such authority. Do not include a copy of the medical or durable POA.

POA or Legal Guardian Name (please print) _____

POA or Legal Guardian Signature X _____ Date ____/____/____

Agent Name (please print) _____ Agent Phone No. (____) _____

Agent Signature _____ Date ____/____/____

Agent ID _____ Farm Bureau Service Center Number _____

Applicant's Farm Bureau Membership Number (if applicable) _____

Wellmark must receive the completed application within 15 days of the Applicant's signature date.

Send completed form to:

Wellmark Blue Cross and Blue Shield of South Dakota
1601 W Madison St
PO Box 5023
Sioux Falls, SD 57117

OR

Email to: updatesindividualmembership@wellmark.com

