Wellmark

Clear Form

Group Membership Change Form
(For all group markets)

Wellmark Blue Cross Blue Shield of Iowa
Wellmark Health Plan of Iowa, Inc.

Independent Licensees of the Blue Cross and Blue Shield Association

Please submit changes as they occur.
Complete one form per employee.

☐ **Large Group Membership**
Wellmark Blue Cross and Blue Shield of Iowa
PO Box 9232 - Station 3W294
Des Moines, IA 50306-9232
Fax: (515) 376-9047

☐ **Mid-Size and Small Business Membership**
Wellmark Blue Cross and Blue Shield of Iowa
PO Box 9232 - Station 3W297
Des Moines, IA 50306-9232
Fax: (515) 376-9042

Complete the following information

Group Name

Group Contact

Group Number

(_____)_____
Group Phone Number

Employee Name (First, Last)	Employee ID#	Phone No. (_____)_____-_____

ADDRESS CHANGE

Old Street Address	Apt. No.	New Street Address	Apt. No.
City	**State** **Zip**	**City**	**State** **Zip**

NAME CHANGE

Name currently appearing on Membership Records	Name to appear on updated Membership Records

CANCELS: The Date of Event is the actual date the marriage, termination, divorce or other event occurred. The Cancel Date is the date that the coverage will be cancelled. Wellmark will apply eligibility requirements based on the date of the event and the receipt date.

CANCELS: EMPLOYEE AND ENTIRE CONTRACT

Cancel Code (see below)	Date of Event	Cancel Date	Type of Coverage Canceled
	/ /	/ /	☐ Health ☐ Dental

CANCELS: DEPENDENT AND/OR SPOUSE OR DOMESTIC PARTNER ONLY

Dependent or Spouse/ Domestic Partner	Dependent or Spouse/Domestic Partner Name	Cancel Code (see below)	Date of Event	Cancel Date	Type of Coverage Canceled
D/S			/ /	/ /	☐ Health ☐ Dental
D/S			/ /	/ /	☐ Health ☐ Dental
D/S			/ /	/ /	☐ Health ☐ Dental

Cancel Reason Code List

01 Dependent Reaching Maximum Age
02 Dependent Over Maximum Age No Longer a Student
03 Full-time Student Dependent Over Maximum Age Marries
04 Divorce/Dissolution of Marriage
05 Termination of Employment
06 Active Military Duty
07 Death
08 Other (please specify) _____

ADDING DEPENDENTS:

1. Notification must be sent within 60 days of the event. Additionally, you must enroll within 60 days after you lose eligibility for coverage under Medicaid or CHIP or become eligible for Medicaid or CHIP premium assistance.
2. An application *must* be submitted if you are adding a spouse, or if you are adding a dependent child pursuant to a court order.
3. An application *must* be submitted if adding a dependent changes the type of contract your group offers, i.e., single to family, single to two-person. A change in contract type usually results in a premium change, most often a premium increase. Events with a change in contract type that would require an application include:
   - Birth
   - Adoption
   - Addition of a stepchild, foster child or child for whom the employee is legal guardian
   - Addition of a natural child
   - Dependent resuming full-time student status

If adding a dependent child requires no change in contract type, complete the following:

Employee Name (First, Last)	Employee ID#	Group Number

ADD DEPENDENT CHILD

Dependent (First, Last)	Dependent Social Security Number / Tax Identification Number[1]	☐ Yes ☐ No Soc. Sec. Disabled? ☐ Yes ☐ No Medicare Enrolled?

Date of Event _____/_____/_____ Dependent Date of Birth _____/_____/_____ Gender ☐ Female ☐ Male

Event Type: ☐ Birth ☐ Adoption/Legal Custody (Provide Legal Documentation)
☐ Dependent Loss of Coverage ☐ Dependent Resuming Full-Time Student Status ☐ Other _____

Dependent (First, Last)	Dependent Social Security Number / Tax Identification Number[1]	☐ Yes ☐ No Soc. Sec. Disabled? ☐ Yes ☐ No Medicare Enrolled?

Date of Event _____/_____/_____ Dependent Date of Birth _____/_____/_____ Gender ☐ Female ☐ Male

Event Type: ☐ Birth ☐ Adoption/Legal Custody (Provide Legal Documentation)
☐ Dependent Loss of Coverage ☐ Dependent Resuming Full-Time Student Status ☐ Other _____

[1]Social Security number (SSN) or tax identification number (TIN) must be provided for every covered member.

OTHER CARRIER INFORMATION (Complete only if adding dependent(s).)

☐ Yes ☐ No Will you, your spouse or domestic partner, or your dependent(s) keep other coverage in addition to this coverage?

If yes, list name(s) of applicants keeping other coverage _____

Provide complete information below:

Other Insurance Carrier Name _____

Address Line 1 (Street Address) _____

Address Line 2 (PO Box) _____

City _____ State _____ ZIP _____

If the other coverage is another BCBS carrier in another state, indicate carrier name and state _____

Policyholder Name _____ Policyholder Birthdate _____/_____/_____

List dependent(s) covered under policy _____

List name of person who has primary responsibility for the dependent(s)_____

☐ Yes ☐ No Is there a court order that requires one parent to provide health insurance coverage for any dependent?

Other Coverage Effective Date _____/_____/_____ Other Coverage End Date _____/_____/_____

AUTHORIZATION AND CERTIFICATION

I certify that I am legally authorized to submit this Group Membership Change Form ("Form") for the purpose of requesting the membership changes described herein. I understand that the changes requested in this Form will not start until this Form is received and accepted by Wellmark.

In order for Wellmark to report your coverage status to the federal government, you must provide to us your Social Security number or tax identification number and the Social Security numbers or tax identification numbers of all members covered under your coverage. The IRS requires that Wellmark report this information using the Social Security number or tax identification number of the plan member and each dependent. If Wellmark does not have Social Security or tax identification numbers, we will be unable to report and send the information needed to complete federal tax returns. If you have not previously provided your Social Security number or tax identification number to Wellmark for all members covered under your coverage, you should contact us by calling the Customer Service number on the back of your ID card. If you do not provide the Social Security number or taxpayer identification numbers to Wellmark for this purpose, you will be subject to a $50 penalty per violation imposed by the Internal Revenue Service.

I further certify that, after this Form was completed, I carefully and fully read it and 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 Wellmark will rely on the completeness and truthfulness given in the statements in this Form and that if I have made any false statements or misrepresentations in the Form or have failed to disclose or have concealed any material fact, Wellmark will be entitled to declare coverage provided pursuant to this Form void and to refuse allowance on benefits to any person receiving coverage pursuant to this Form. **Any person who intentionally defrauds or knowingly facilitates fraud against an insurer by submitting information that contains a false, incomplete or deceptive statement may be guilty of insurance fraud.**

I have read and understand the Authorization and Certification language on this form.

_____ _____/_____/_____

Member/Authorized Group/Authorized Broker Signature Date