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

Independent Licensees of the Blue Cross and Blue Shield Association

Group Membership Change Form for Small Business ACA Plans (1-50)

(For Groups Effective 1/1/14 and After)

Complete the following information

____
Group Name

____
Group Contact

____
Group Number

(______)______________________
Group Phone Number

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

☐ **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
Email: smgrpmemapp@wellmark.com

Employee Name (First, Last)	Wellmark ID#	Phone No. (______)______-___________

ADDRESS CHANGE

Old Address	Apt. No.	New Address	Apt. No.
City / State / Zip		City / State / Zip	
Update Email Address			

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 will be the end of the month in which the event occurs. If a dependent is being removed without an event, the term date will be the end of the month following signature of the form.

CANCELS: EMPLOYEE AND ENTIRE CONTRACT

Cancel Code (see below)	Date of Event	Cancel Date	Type of Coverage Canceled
	/ /	/ /	☐ Health ☐ Dental ☐ Avesis Vision[1]

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 ☐ Avesis Vision[1]
D / S			/ /	/ /	☐ Health ☐ Dental ☐ Avesis Vision[1]
D / S			/ /	/ /	☐ Health ☐ Dental ☐ Avesis Vision[1]

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) _________

[1]The vision plan is provided by Avesis Vision, an independent company that does not provide Wellmark Blue Cross and Blue Shield products or services. Avesis Vision is underwritten by Fidelity Security Life Insurance Company, Kansas City, Missouri. If a member's health coverage is canceled, the Avesis Vision coverage must also be canceled (if applicable).

ADDING DEPENDENTS:

1. Notification must be sent within 60 days of the event. Additionally, you must enroll within 60 days of being notified that you are no longer eligible for coverage under Medicaid or CHIP or become eligible for Medicaid or CHIP premium assistance.
2. A Group Employee Application for Health, Dental and Vision/Hearing Insurance (1-50) *must* be submitted if you are adding a spouse, or if you are adding a dependent child pursuant to a court order.
3. A Group Employee Application for Health, Dental and Vision/Hearing Insurance (1-50) *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
   - Addition of a stepchild, foster child or child for whom the employee is legal guardian
   - Adoption
   - 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)	Wellmark 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 __________

Primary Care Provider Information (complete if your benefit plan requires you to select a PCP)

PCP's First and Last Name__________

PCP's Address (office location where you will receive services)__________

____

Are you an established patient? ☐ Yes ☐ No

OB/GYN's First and Last Name__________

OB/GYN's Address (office location where you will receive services)__________

____

Are you an established patient? ☐ Yes ☐ No

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 __________

Primary Care Provider Information (complete if your benefit plan requires you to select a PCP)

PCP's First and Last Name__________

PCP's Address (office location where you will receive services)__________

____

Are you an established patient? ☐ Yes ☐ No

OB/GYN's First and Last Name__________

OB/GYN's Address (office location where you will receive services)__________

____

Are you an established patient? ☐ Yes ☐ No

[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 ______________________________ Policy ID#______________________

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 for Small Business ACA Plans (1-50) (“Form”), on behalf of myself or the above named employee, 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