Group Membership Change Form

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 - Groups 101+**
Wellmark Blue Cross and Blue Shield of Iowa
PO Box 9232 - Station 3W294
Des Moines, IA 50306-9232
Fax (515) 376-9047

❑ **Small Group Membership - Groups 2-100**
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 ❑ Life ❑ Disability

CANCELS: DEPENDENT AND/OR SPOUSE ONLY

Dependent or Spouse	Dependent or Spouse Name	Cancel Code (see below)	Date of Event	Cancel Date	Type of Coverage Canceled
D / S			/ /	/ /	❑ Health ❑ Dental ❑ Life ❑ Disability
D / S			/ /	/ /	❑ Health ❑ Dental ❑ Life ❑ Disability
D / S			/ /	/ /	❑ Health ❑ Dental ❑ Life ❑ Disability

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) __________

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

______________________________ ________/________/________
Member/Authorized Group/Authorized Broker Signature Date

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ADDING DEPENDENTS:

1. Notification must be sent within 31 days (or within 60 days of birth, adoption or placement for adoption for fully insured and self-funded non-ERISA groups) of 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 adding a spouse or a natural child by 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 of a child
   - Addition of a stepchild, foster child or child for whom the employee is legal guardian
   - Adoption of a child
   - 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 SS# (if available)	❑ Yes ❑ No Soc. Sec. Disabled? ❑ Yes ❑ No Medicare Enrolled?

Date of Event ____/____/____ Dependent Date of Birth ____/____/____ Gender ❑ Female ❑ Male

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

Dependent (First, Last)	Dependent SS# (if available)	❑ Yes ❑ No Soc. Sec. Disabled? ❑ Yes ❑ No Medicare Enrolled?

Date of Event ____/____/____ Dependent Date of Birth ____/____/____ Gender ❑ Female ❑ Male

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

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

❑ Yes ❑ No Will you, your spouse or your dependents keep other health coverage in addition to this Wellmark, Inc. coverage? If yes, please complete the following:

Policyholder Name (First, Last): ________________ Date of Birth: ___/___/___

Please list those covered by other health plan(s):________________

Policy No.: ________________ Effective Date: ___/___/___

Employer Name (if coverage is through employer group): ________________

Insurance Company/HMO Name and Address or Phone Number: ________________

❑ Yes ❑ No Is there a divorce decree/court order that requires one parent to provide health insurance coverage for any dependent? If yes, please complete the following:

List dependent(s): ________________

List name of person required to provide health insurance: ________________

List name of person who has primary physical custody: ________________

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. 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, with intent to defraud or knowing that they are facilitating a fraud against an insurer, submits information containing a false, incomplete or deceptive statement may be guilty of insurance fraud.**

Please sign and date

________________________ ____/____/____
Member/Authorized Group/Authorized Broker Signature Date

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