Wellmark

Wellmark Blue Cross and Blue Shield of Iowa and Wellmark Health Plan of Iowa, Inc. are independent licensees of the Blue Cross and Blue Shield Association.

Group Membership Change Form

(For all non-ACA group markets)

Please submit changes as they occur.

Complete one form per employee.

Failure to submit all pages and fill out this change form completely and legibly may result in a delay in requested changes.

Complete the following information

Group Name

Group Contact

Group Number

(_____)_____
Group Phone Number

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

☐ **Mid-Size and Small Group Membership**
Wellmark Blue Cross and Blue Shield of Iowa
PO Box 9232 - Mail Station 3W297
Des Moines, IA 50306-9232
Fax: (515) 376-9042
Email: updatesgroupmembership@wellmark.com

Employee Name (First, Last)	Wellmark ID#

A. ADDRESS CHANGE

Old Address, including apartment number	New Address, including apartment number
City, State, ZIP	City, State, ZIP

Phone Numbers	Phone Numbers	Phone Numbers
Home: (_____)_____	Work: (_____)_____	Mobile: (_____)_____

Email Address (optional)

B. 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 cancel date will be the end of the month following signature of this form.

C1. CANCELS: EMPLOYEE AND ENTIRE CONTRACT

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

C2. 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/DP					☐ Health ☐ Dental
☐ D / ☐ S/DP					☐ Health ☐ Dental
☐ D / ☐ S/DP					☐ 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) _____

D1. ADD DEPENDENT CHILD, SPOUSE/DOMESTIC PARTNER TO EXISTING COVERAGE

If you need to list more than three dependents, please write all necessary information on a separate sheet of paper and attach to this change form. Your employer determines eligibility for coverage. Please confirm with your employer that the dependent types listed below are eligible. 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.

D2. EVENT TYPE

Special Enrollment Event Reason:

- ☐ Birth
- ☐ Marriage/common law
- ☐ Divorce/dissolution of domestic partnership[1]
- ☐ Adoption or placement for adoption
- ☐ Court-ordered coverage
- ☐ Legal guardianship
- ☐ Foster child placement
- ☐ Involuntary loss of creditable coverage
- ☐ Permanent move to Iowa
- ☐ Returning from military service
- ☐ Domestic partnership[1] (Certification of Domestic Partnership form required)
- ☐ Other:______________________________

List date of special enrollment event _____/_____/_____ (mm/dd/yyyy) (or last day of coverage)

	Name (First, MI, Last)	Date of Birth (mm/dd/yyyy)	Social Security Number/Tax Identification Number[2]	Gender	FT Student[3]	Disabled[3]
☐ Spouse ☐ Domestic Partner[1]			a. SSN/TIN__________ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ Male ☐ Female	N/A	N/A
☐ Child			a. SSN/TIN__________ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child			a. SSN/TIN__________ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child			a. SSN/TIN__________ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No

[1]NOTE: Some plan options may not provide coverage for Domestic Partners. For more information, contact your Wellmark representative.
[2]The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Wellmark will follow up with you to collect this information if you do not check/complete a., b., or c. for each person listed. Failure to provide the SSN/TIN information may result in a monetary penalty, per violation, assessed to you by the IRS.
[3]Please review your coverage manual for dependent eligibility or contact your Wellmark representative.

E. COVERAGE SELECTED

Mark each box for products you are selecting and indicate the plan name.

☐ Health[4]______________________________

[4]If you're enrolling in an HMO/WHPI plan a Primary Care Provider (PCP) must be elected for each family member. Please vist www.myWellmark.com to select your PCP.

- ☐ Employee
- ☐ Employee + Child(ren)
- ☐ Employee + Spouse/Domestic Partner
- ☐ Employee + Spouse/Domestic Partner + Child(ren)

☐ Dental______________________________

- ☐ Employee
- ☐ Employee + Child(ren)
- ☐ Employee + Spouse/Domestic Partner
- ☐ Employee + Spouse/Domestic Partner + Child(ren)

F. MEDICARE COVERAGE REQUIRED

Required if Medicare enrolled, absence of a response on questions (1) or (2) will be considered as a response of "No".

1. Are you or anyone listed on this form Social Security disabled? ☐ Yes ☐ No
2. Are you or anyone listed on this form Medicare enrolled? ☐ Yes ☐ No

Name as it appears on Medicare Card______________________________

Part A _____/_____/_____ Part B _____/_____/_____ Part D _____/_____/_____

Name as it appears on Medicare Card______________________________

Part A _____/_____/_____ Part B _____/_____/_____ Part D _____/_____/_____

G. OTHER CARRIER INFORMATION (Complete only if adding spouse/domestic partner and/or 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, please complete the following:

Policyholder Name (First and Last): _____

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

Policy Number: _____ Effective Date: _____/_____/_____

Insurance Company/HMO Name:_____

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?

H. 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 monetary penalty per violation imposed by the Internal Revenue Service.

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 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