



Group Membership Change Form

Wellmark BlueCross BlueShield of Iowa
Wellmark Health Plan of Iowa, Inc.

Independent Licensees of the Blue Cross and Blue Shield Association

Complete the following information

Group Name _____

Group Contact _____

Group Number _____

(_____) _____
Group Phone Number

Please submit changes as they occur.

- Large Group Membership - Groups 101+
 Small Group Membership - Groups 2-100

All changes should be indicated on this form and faxed or mailed to:

Wellmark Blue Cross and Blue Shield of Iowa
PO Box 680
Carlisle, IA 50047-0680
Fax (866) 574-3546

ADDRESS CHANGE

Employee Name (First, Last)	Phone No.	Employee ID#	Phone No.
Old Street Address	Apt. No.	New Street Address	Apt. No.
City	State	Zip	City State Zip
Employee Name (First, Last)	Phone No.	Employee ID#	Phone No.
Old Street Address	Apt. No.	New Street Address	Apt. No.
City	State	Zip	City State Zip

NAME CHANGE

Employee Name (First, Last)	Employee ID#
Name currently appearing on Membership Records	Name to appear on updated Membership Records

CANCELS: Use the actual date of the event (for example, date of marriage, date of termination, date other coverage canceled) rather than the date you want coverage canceled. Using the event date you provide, Wellmark will determine the cancellation date based on each group's eligibility requirements.

CANCELS: EMPLOYEE AND ENTIRE CONTRACT

Employee Name	Employee ID#	Cancel Code (see below)	Date of Event	Type of Coverage Canceled
			/ /	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Disability
			/ /	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Disability
			/ /	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Disability

CANCELS: DEPENDENT AND/OR SPOUSE ONLY

Employee Name	Employee ID#	Dependent or Spouse	Dependent or Spouse Name	Cancel Code (see below)	Date of Event	Type of Coverage Canceled
		D / S			/ /	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Disability
		D / S			/ /	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Disability
		D / S			/ /	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Disability

Cancel Reason Code List

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

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

Member/Authorized Group/Authorized Broker Signature _____

_____/_____/_____
Date

ADDING DEPENDENTS:

1. An application *must* be submitted if adding a spouse.
2. An application *must* be submitted if adding 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
 - Adoption of a child
 - Addition of a natural child
 - Addition of a stepchild, foster child or child for whom the employee is legal guardian
 - Dependent resuming full-time student status

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

ADDING DEPENDENTS: 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 coverage under Medicaid or CHIP or become eligible for Medicaid or CHIP premium assistance.

ADD DEPENDENT CHILD

Employee Name (First, Last)	Employee ID#
Dependent (First, Last)	Dependent SS# (if available)
Date of Event ____/____/____ Dependent Date of Birth ____/____/____ Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	
Event Type: <input type="checkbox"/> Birth of Newborn <input type="checkbox"/> Adoption/Legal Custody (Provide Legal Documentation) <input type="checkbox"/> Dependent Loss of Coverage <input type="checkbox"/> Dependent Resuming Student Status <input type="checkbox"/> Other _____	
Employee Name (First, Last)	Employee ID#
Dependent (First, Last)	Dependent SS# (if available)
Date of Event ____/____/____ Dependent Date of Birth ____/____/____ Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	
Event Type: <input type="checkbox"/> Birth of Newborn <input type="checkbox"/> Adoption/Legal Custody (Provide Legal Documentation) <input type="checkbox"/> Dependent Loss of Coverage <input type="checkbox"/> Dependent Resuming Student Status <input type="checkbox"/> Other _____	
Employee Name (First, Last)	Employee ID#
Dependent (First, Last)	Dependent SS# (if available)
Date of Event ____/____/____ Dependent Date of Birth ____/____/____ Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	
Event Type: <input type="checkbox"/> Birth of Newborn <input type="checkbox"/> Adoption/Legal Custody (Provide Legal Documentation) <input type="checkbox"/> Dependent Loss of Coverage <input type="checkbox"/> Dependent Resuming Student Status <input type="checkbox"/> Other _____	

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