Wellmark

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)

Please submit changes as they occur and 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

Infoweb Systems, Inc.
Group Name

Group Contact

00078004
Group Number

(_____)_____
Group Phone Number

Small Business Membership
Wellmark Blue Cross and Blue Shield of Iowa
Station 3W297
PO Box 9232
Des Moines, IA 50306-9232
Fax: (515) 376-9042
Email: smgrpmemapp@wellmark.com

Employee Name (First, Last)	Wellmark ID#

ADDRESS CHANGE

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

Phone No.
Home: (_____) _____ - _____ Work: (_____) _____ - _____ Mobile: (_____) _____ - _____

Email Address (optional)

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 ☐ Vision/Hearing[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 ☐ Vision/Hearing[1]
D / S			/ /	/ /	☐ Health ☐ Dental ☐ Vision/Hearing[1]
D / S			/ /	/ /	☐ Health ☐ Dental ☐ Vision/Hearing[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 and the hearing discount savings plan is provided by EPIC Hearing Healthcare. Avesis Vision and EPIC Hearing Healthcare are independent companies that do 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 vision/hearing coverage must also be canceled (if applicable).

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

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.

Event Type

Special Enrollment Event Reason:

- ☐ Birth
- ☐ Marriage/common law
- ☐ Divorce/dissolution of domestic partnership
- ☐ 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
- ☐ 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]	Medicare[3]
☐ Spouse ☐ Domestic Partner		_____/_____/_____	a. SSN/TIN: ________ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ Male ☐ Female	N/A	N/A	☐ 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	☐ 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	☐ 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	☐ Yes ☐ No

[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 $50 penalty, per violation, assessed to you by the IRS.

[3]Dependent(s) age 26 or older must be unmarried and either a full time student or a disabled dependent. If the dependent is enrolled in Medicare, submit a copy of his/her Medicare card.

COVERAGE SELECTED

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

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

2. Vision/Hearing may only be selected if you have selected a health plan:
   ☐ Vision/Hearing
   - ☐ Employee ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren)
   - ☐ Employee + Spouse/Domestic Partner + Child(ren)

   Pediatric vision coverage for children age 18 and under is included in your Wellmark health plan. Pediatric vision coverage will discontinue at the end of the month the child turns age 19.

3. ☐ Dental[4]
   - ☐ Employee ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren)
   - ☐ Employee + Spouse/Domestic Partner + Child(ren)

[4]This policy does not include pediatric dental coverage. Pediatric dental coverage is available in the insurance market and can be purchased as a stand alone product. Please contact your agent or visit Iowa's Marketplace if you wish to purchase stand alone pediatric dental coverage or a stand alone dental product.

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

PERSONAL DOCTOR: Please choose a Personal Doctor for each member of your family. This information is required for applicants who have an HMO or Blue Rewards℠ plan. The personal doctor designation is only for applicants who live in Iowa. You can choose from among five different provider types: General/Family Practice Physicians, Internists, Nurse Practitioners, Physician Assistants, or Pediatricians. The personal doctor you choose must participate in the network associated with your plan. In addition, female members may choose an OB/GYN. You can access the Wellmark provider directory at wellmark.com/HealthAndWellness/FindaDoctor/ProviderFinder/Doctor/Search or by calling 1-800-524-9242. You may also see a Personal Doctor referred to as a Primary Care Provider (PCP) in other Wellmark documentation.

Spouse or Domestic Partner

Doctor Name: _____

Doctor Address Line 1 (Street Address or Apt/Suite#): _____

Doctor Address Line 2 (PO Box, Street Address): _____

City:_____ State:_____ ZIP:_____

☐ Yes ☐ No Are you an established patient?

OB/GYN Name (optional):_____

OB/GYN Address Line 1 (Street Address or Apt/Suite#): _____

OB/GYN Address Line 2 (PO Box, Street Address): _____

City:_____ State:_____ ZIP:_____

☐ Yes ☐ No Are you an established patient?

Dependent 1

Doctor Name: _____

Doctor Address Line 1 (Street Address or Apt/Suite#): _____

Doctor Address Line 2 (PO Box, Street Address): _____

City:_____ State:_____ ZIP:_____

☐ Yes ☐ No Are you an established patient?

OB/GYN Name (optional):_____

OB/GYN Address Line 1 (Street Address or Apt/Suite#): _____

OB/GYN Address Line 2 (PO Box, Street Address): _____

City:_____ State:_____ ZIP:_____

☐ Yes ☐ No Are you an established patient?

Dependent 2

Doctor Name: _____

Doctor Address Line 1 (Street Address or Apt/Suite#): _____

Doctor Address Line 2 (PO Box, Street Address): _____

City:_____ State:_____ ZIP:_____

☐ Yes ☐ No Are you an established patient?

OB/GYN Name (optional):_____

OB/GYN Address Line 1 (Street Address or Apt/Suite#): _____

OB/GYN Address Line 2 (PO Box, Street Address): _____

City:_____ State:_____ ZIP:_____

☐ Yes ☐ No Are you an established patient?

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

PERSONAL DOCTOR, cont'd.

Dependent 3

Doctor Name: _____

Doctor Address Line 1 (Street Address or Apt/Suite#): _____

Doctor Address Line 2 (PO Box, Street Address): _____

City:_____ State:_____ ZIP:_____

☐ Yes ☐ No Are you an established patient?

OB/GYN Name (optional):_____

OB/GYN Address Line 1 (Street Address or Apt/Suite#): _____

OB/GYN Address Line 2 (PO Box, Street Address): _____

City:_____ State:_____ ZIP:_____

☐ Yes ☐ No Are you an established patient?

OTHER COVERAGE (Complete only if adding spouse/domestic partner 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, list name(s) of applicants keeping other coverage _____

Provide complete information below:

Other Insurance Carrier Name _____

Address Line 1 (Street Address or Apt/Suite#) _____

Address Line 2 (PO Box, Street Address) _____

City _____ State _____ Zip Code _____

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

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 that has primary responsibility for the dependent(s)_____

☐ Yes ☐ No Is there a court ordered document?

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

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. If I am submitting this form on behalf of the above named employee, I certify that I have provided the following disclosures. 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 my coverage status to the federal government, I must provide to Wellmark my Social Security number or tax identification number and the Social Security numbers or tax identification numbers of all members covered under my 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, I understand Wellmark will be unable to report and send the information needed to complete federal tax returns. If I have not previously provided Social Security numbers or tax identification numbers to Wellmark for all members covered under my coverage, I will contact Wellmark by calling the Customer Service number on my ID card. If I do not provide the Social Security numbers or tax identification numbers to Wellmark for this purpose, I may 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 Agent Signature Date