Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc., Wellmark Synergy Health, Inc. and Wellmark Value Health Plan, Inc. are 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:**

Group Name ______________________

Group Contact ______________________

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, including apartment number | New Address, including apartment number |
|---|---|
| City, State, Zip | City, State, Zip |

| Phone Numbers<br>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[2] ONLY

| Dependent or Spouse / Domestic Partner | Dependent or Spouse / Domestic Partner[2] Name | Cancel Code (see below) | Date of Event | Cancel Date | Type of Coverage Canceled |
|---|---|---|---|---|---|
| D S/DP | | | | | Health Dental Vision/Hearing[1] |
| D S/DP | | | | | Health Dental Vision/Hearing[1] |
| D S/DP | | | | | 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, 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 vision/hearing coverage must also be canceled (if applicable).

[2]Some plan options may not provide coverage for Domestic Partners. For more information, contact your Wellmark Representative.

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

**ADD DEPENDENT CHILD, SPOUSE/DOMESTIC PARTNER[4] 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 from. 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[4]
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[4] (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]** | **Medicare[3]** |
|---|---|---|---|---|---|---|---|
| Spouse Domestic Partner[4] | | | a. SSN/TIN:__________<br>b. Does not have an SSN/TIN<br>c. I refuse to provide the SSN/TIN | Male<br>Female | N/A | N/A | Yes<br>No |
| Child | | | a. SSN/TIN:__________<br>b. Does not have an SSN/TIN<br>c. I refuse to provide the SSN/TIN | Male<br>Female | Yes<br>No | Yes<br>No | Yes<br>No |
| Child | | | a. SSN/TIN:__________<br>b. Does not have an SSN/TIN<br>c. I refuse to provide the SSN/TIN | Male<br>Female | Yes<br>No | Yes<br>No | Yes<br>No |
| Child | | | a. SSN/TIN:__________<br>b. Does not have an SSN/TIN<br>c. I refuse to provide the SSN/TIN | Male<br>Female | Yes<br>No | Yes<br>No | Yes<br>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]Some plans do not provide coverage for disabled dependents age 26 or older. For more information, contact your Wellmark representative. If the dependent is enrolled in Medicare, submit a copy of his/her Medicare card.
[4]NOTE: Some plan options may not provide coverage for Domestic Partners. For more information, contact your Wellmark representative.

## COVERAGE SELECTED

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

1. Health
   Employee
   Employee + Spouse/Domestic Partner[5]
   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[5]
   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[5]
   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.

[5]NOTE: Some plan options may not provide coverage for Domestic Partners. For more information, contact your Wellmark representative.

| 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, including family members who live outside of Iowa. The Personal Doctor designation is not for applicants who permanently live outside of Iowa. You can choose from among five different provider types: General/Family Practice Physicians, Internists, Nurse Practitioners, Physician Assistants, or Pediatricians. The person 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/FindaDoctor.aspx 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[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 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?

[1]NOTE: Some plan options may not provide coverage for Domestic Partners. For more informatin, contact your Wellmark representative.

| 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[1] or dependent[s].)

Yes No Will you, your spouse or domestic parnter, or dependent(s) keep other coverage in adition 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:___________

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?

**AUTHORIZATION AND CERTIFICATION**

I certify that I am legally authorized to submit this Group Membership Change Form for Small Group 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 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 the 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.**

**Print Name** ___________________________

**Your Signature X**___________________________ **Date Signed** ______/______/______

**If applicant is a minor, please sign below. (If legal guardian, please provide proof of guardianship)**

**Power of Attorney/Legal Guardian Printed Name** ___________________________

**Power of Attorney/Legal Guardian Signature X**___________________________ **Date Signed** ______/______/______

# Required Federal Accessibility and Nondiscrimination Notice

**Discrimination is against the law**

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Wellmark does not exclude people or treat them differently because of their race, color, national origin, age, disability or sex.

**Wellmark provides:**

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 5W189, Des Moines, IA 50309-2901, 515-376-4500, TTY 888-781-4262, Fax 515-376-9073, Email CRC@Wellmark.com. You can file a grievance in person, by mail, fax or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone or fax at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

---

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。 请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية, فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ທີ່. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, निःशुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တၢ်ဒုးသ့ၣ်ညါ–နမ့ၢ်ကတိၤကညီကျိာ်,ကျိာ်တၢ်မၤစၢၤတၢ်ဖိးတၢ်မၤတဖၣ်,လၢတဘၣ်လၢာ်ဘူးလဲ,အိၣ်လၢနဂီၢ်လီၤ.ဆဲးကျိးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ၢ်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ၢ်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि निःशुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ይደውሉ ያነጋግሩን።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heɓir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhólǫ́. Kojį' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

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

09/16 A