SMALL EMPLOYER GROUP CHANGE/UPDATE FORM

Thank you for your business. This form was developed to help simplify the administrative change request process.

Instructions: Please complete this form for all changes or updates requested for your group coverage. Indicate which group numbers are impacted by this change request. **The form must be signed and dated by the authorized signer for your company.** For some changes you may also be required to complete a small group employer application.

Indicate the benefits and applicable group numbers affected by this change request:

Health group number(s): _____

Dental group number:_____

Life/disability group number(s): _____

Employer name: _____

If you are an ERISA plan sponsor, please provide your ERISA plan name if it is different from your group's legal name:

_____

Does your plan have 25 percent or more of all plan participants literate in the same non-English language?

- ☐ Yes
  - If yes, list language(s):

_____

- ☐ No

SECTION A – EMPLOYEE ELIGIBILITY CHANGES

Eligibility change requests must be received by Blue Cross and Blue Shield of Minnesota (Blue Cross) on or before the 15th of the month before the renewal. This change will impact employees hired after the effective date of the change. Fax your changes to Blue Cross at **(651) 662-7544**.

1. Coverage waiting period:
   - ☐ None (date of hire)
   - ☐ 30 days
   - ☐ 60 days
   - ☐ 90 days

2. Benefit will begin on (select one):
   - ☐ Date of hire (only available with NONE)
   - ☐ Next day after completion of coverage effective date (not available with NONE)
   - ☐ First day of the month after completion of coverage effective date (not available with 90 days)

3. How many hours per weeks does an employee have to work to be considered eligible for coverage? _____ (minimum of 20 hours per week for reform groups and 30 hours per week for non-reform groups.)

4. Who is eligible for coverage (for example, all full-time employees, non-union only, etc.):

_____

_____

5. Employer contribution percentage (health): _____ percent employee; _____percent dependent
(Employers are required to contribute a minimum of 50 percent of the employee premium)

Employer contribution percentage (life): _____percent employee; _____percent dependent
(Employers are required to contribute a minimum of 50 percent of the employee premium)

Employer contribution percentage (dental): _____percent employee; _____percent dependent

6. Domestic partner coverage:
   - ☐ No
   - ☐ Yes, same or opposite gender

SECTION B – EMPLOYER INFORMATION CHANGES

A change in ownership, merger with another company, or split of an existing company should be coordinated through your agent and Blue Cross. A change in the physical address of your business
may result in a change in the area rate factor, which will impact the group rates. *In order to process*
any change we may need to obtain additional information.

1. Contact person (group leader): _____

2. Person authorized to make changes to the group contract: _____

3. Telephone number: ( ) _____

4. Fax number: ( ) _____

5. Group name*: _____

6. Physical address (include county)*: _____

7. Billing address*: _____

*You must provide details and dates concerning the reason for changes in the group name or address:

_____

_____

_____

SECTION C – NEW MEDICARE SECONDARY PAYER REPORTING REQUIREMENTS

Section 111 of the federal Medicare, Medicaid, and SCHIP Extension Act of 2007 requires carriers to participate in a Medicare Secondary Payer (MSP) data exchange with the Centers for Medicare & Medicaid Services (CMS). The data is being requested by CMS in order to identify Medicare beneficiaries whose group health plan or other coverage is primary to Medicare. The law identifies group health plan carriers as being Responsible Reporting Entities (RRE) required to gather the necessary data elements.

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross), as RREs, must gather the required data and submit files to CMS on a quarterly basis. Since January 1, 2009, we have been required to gather the following information from employers:

- Employee count (both full-time and part-time employees – whether or not covered under the group health plan)
- Tax identification number (TIN) or employer identification number (EIN) for all groups, regardless of coverage effective date.

Thank you for your cooperation in helping us comply with the new federal reporting requirements.

Please provide this information if it has changed since previously submitted to Blue Cross.You must provide details and dates concerning the reason for changes to your TIN:

_____

_____

_____

1. Please check one of the following boxes, indicating your total full- and part-time employee count, including those who do not have Blue Cross or Blue Plus coverage:
   - ☐ 1 to 19 total employees
   - ☐ 20 to 99 total employees
   - ☐ 100 or more total employees

2. TIN or EIN
   Please write your federal TIN/EIN number here:_____

   If you do not have a TIN or EIN, please write your Social Security number here:
   _____

The form must be signed and dated by the authorized signer for your company.

Authorized signer: _____ Signature date: _____

(Print name): _____

E-mail: _____

Please fax the completed form to: (651) 662-7544, Attn: Small Group Set Up Department, or
Mail to: Group Set Up Department M3-40
Blue Cross and Blue Shield of Minnesota
PO Box 64560
St. Paul, MN 55164-0560