Small Employer Group Change/Update Form

BlueCross BlueShield Minnesota

Thank you for your business. Use this form to simplify requested changes/updates to your coverage.

Instructions:

- Indicate which products and client or group numbers are impacted by this request.
- Coordinate the following changes with the Employer/Group's agent and Blue Cross and Blue Shield of Minnesota (Blue Cross): a change in ownership, merger or acquisition with another company, split of an existing company, or renewal date change.
- Most eligibility changes can be sent prior to renewal to your agent to process on benefits manager at renewal. Other changes can be sent directly to Blue Cross at any time of the year.
- A change in the physical address of the Employer/Group's business may impact premium rates.
- Some changes may require more information, such as a new small group business application.
- This form must be signed and dated by the authorized representative.

Health client number: _____

Dental group number: _____

Vision group number: _____

Employer name: _____

Federal ID/EIN: _____

If the Employer/Group is an ERISA plan sponsor, please provide the ERISA plan name of it is different from the client's legal name:

_____

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

☐ Yes List language(s):_____

☐ No

Does the Employer/Group have an Individual Coverage Health Reimbursement Arrangement (ICHRA)?

☐ Yes

☐ No

If Yes, please provide the class(es) of employees who are eligible for the ICHRA:

_____

_____

SECTION A – EMPLOYEE ELIGIBILITY CHANGES

Eligibility: Most changes can be done by the Employer/Group's agent on benefits manager. Requests must be received by Blue Cross on or before the 20th of the month before the renewal.

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

2. Benefit will begin on (select one):
   - ☐ Hire date (only available with NONE)
   - ☐ Next day following (not available with NONE)
   - ☐ First day of next month following (not available with 90 days)

3. Number of hours employees must work per week to be considered eligible for coverage: _____
   (minimum of 20 hours per week)

4. **Employer** contribution percentage (health): percent employee _____; percent dependent _____
   (Employers are required to contribute at least 50 percent of the employee's total monthly medical premium).

   Employer contribution percentage (dental): percent employee _____; percent dependent _____

   Employer contribution percentage (vision): percent employee _____; percent dependent _____

5. Domestic partner coverage:
   - ☐ No
   - ☐ Yes

SECTION B – EMPLOYER/GROUP INFORMATION CHANGES

1. Client name:_____

2. Physical address (include county): _____

3. Telephone number: _____

4. Email address: _____

5. Authorized representative (must be an owner or employee): _____

6. Billing address and/or contact name: _____

   ☐ Please check box if third-party administrator.

7. Correspondence and/or contact name: _____

   ☐ Please check box if third-party administrator.

8. You must provide details and dates concerning the reason for changes in the Employer/Group name or address:

_____

SECTION C – 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.

Please provide this information if it has changed since previously submitted to Blue Cross.

During this calendar year, how many full-time and part-time employees have you employed with the Employer/Group for at least 20 weeks or more?

- If 20 weeks haven't passed this year, answer using last year's information.
- Include owners, partners and officers as well as full-time, part-time, seasonal, and union employees.
- Do not include independent contractors (1099), retirees, and COBRA participants.

☐ I employed **1 – 19** total employees.
☐ I employed **20 – 99** total employees.
☐ I employed **100** or more total employees.

The form must be signed and dated by the authorized representative of the Employer/Group.

Authorized representative name: _____

Authorized representative signature: _____ **Date:** _____

Email: _____

Please email the completed form to small.group.sales.support@bluecrossmn.com.