

SMALL EMPLOYER GROUP CHANGE 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 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.

Employer name: _____

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

Health group number(s) _____

Dental group number _____

Life/disability group number(s) _____

SECTION A – EMPLOYEE ELIGIBILITY CHANGES

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

1. Coverage waiting period: None 30 days 60 days 90 days

2. Benefit start date: Date of hire (only available if choosing NONE)

First day after completion of waiting period (not available if choosing NONE)

First of month following completion of waiting period (not available if choosing NONE)

3. Number of hours per week to be considered eligible: _____ (minimum of 20 hours per week for reform groups and a minimum of 30 hours per week for non-reform groups.)

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

5. Employer contribution percentage (Health): _____% employee _____% dependent
(Employers are required to contribute a minimum of 50% of the employee premium)

Employer contribution percentage (Life): _____% employee _____% dependent
(Employers are required to contribute a minimum of 50% of the employee premium)

Employer contribution percentage (Dental): _____% employee _____% dependent

6. Domestic partner coverage: No Yes, same gender Yes, same and opposite gender

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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*: _____

8. Tax identification number*: _____

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

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

Authorized signer: _____ Signature date: _____

Printed name: _____

Please fax the completed form to: (651) 662-7544, Attn.: Small Group Set Up Department or

Mail to: Small Group Set Up Department

Route M340

Blue Cross and Blue Shield of Minnesota

P.O. Box 64560

St. Paul, MN 55164-0560



**BlueCross BlueShield
BluePlus
of Minnesota**

Independent licensees of the Blue Cross and Blue Shield Association