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Blue Cross Blue Shield of North Dakota is an independent licensee of the
Blue Cross Blue Shield Association

Renewal and Maintenance Change Request

(For All Group Sizes)

Group Number	Group Name	Current Renewal Month
<input type="text"/>	<input type="text"/>	<input type="text"/>

SECTION A – INFORMATION

Allowed changes are listed in **Section B**. See **Section C** to make changes to contact information.

Please note certain changes may only be made at renewal. Reach out to your Sales contact for details.

Please do **NOT** use this form to make benefit or rate change requests. Submit changes to benefits and rates on a signed rate sheet.

Changes to any of the items directly below require a **Group Change Notification** form to be submitted in addition to this form:

- Name of Business
- Tax ID Number
- Headquarter Location
- Ownership

SECTION B – REQUESTED CHANGE(S)

If you are requesting a change to any of the following, please describe the requested change(s) in the box(es) below and answer the additional questions at the bottom of this page, if applicable. Please refer to your original Group Master Application and any subsequent addendums or amendments.

- Add/Remove Subgroup for Billing Purposes
- Add/Remove Employee Class
- Employer Premium Contribution
- Group Address (specify physical, mailing, billing)
- Add/Remove Online Enrollment Access
- Number of Working Hours for Eligibility
- Domestic Partner Eligibility*
- Probationary Period†
- Health Savings Account Integration**
- Adding a HealthEquity Health Reimbursement Arrangement (HRA)

Description of Requested Change(s)	Requested Effective Date	BCBSND Approval	Comments
<input type="text"/>	<input type="text"/>	☐ Yes ☐ No	<input type="text"/>
<input type="text"/>	<input type="text"/>	☐ Yes ☐ No	<input type="text"/>
<input type="text"/>	<input type="text"/>	☐ Yes ☐ No	<input type="text"/>
Address Change(s)		Identify Which Address(es) are Changing	
<input type="text"/>		☐ Physical ☐ Mailing ☐ Billing ☐ All	

*Domestic Partner Eligibility: Refer to your Sales Representative for rules. Will the group include coverage for domestic partners?
☐ No ☐ Yes

†Probationary Period: If changing to **1st of the month following date of hire**, employees hired on the 1st of the month will be effective on: ☐ their date of hire. ☐ the 1st of the next month.

†Part time to Full Time administration: Part-time employees transferring to full-time will start their probationary periods on the:
☐ original hire date (retroactive). ☐ date the employee transfers to full-time hours.

**Health Savings Account Integration BCBSND offers integration with HealthEquity, an HSA Administrator. If electing to integrate with HealthEquity, who will pay the monthly fee for your employees' health savings accounts (HSA)?
☐ Employer ☐ Employee

How do you intend to contribute to the employees' HSA accounts? (51+ groups only)

- ☐ Annual Seed ☐ Regular Contributions ☐ Payroll Match ☐ Combination Strategy
☐ No contribution



SECTION C – CONTACTS: ADDING, REMOVING OR UPDATING CONTACT INFORMATION

Use this section to make changes to contact information.

☐ Check here if you do **NOT** have any contact changes.

Contact types are described below:

- **Group Administrator** – Handles routine business conversations with the carrier regarding eligibility, billing, rates, renewal notification, contract, benefit booklets and SBCs.
- **Employer Center** – Grants Employer Center access to requested individuals. *Individuals with Employer Center access will default to all available accesses including Online Enrollment if available. If limited access is needed, please contact your Membership Administrator. †The Primary Employer Center contact may not be a producer or employee of a producer.
- **Billing** – Receives invoice from the carrier with eligibility and amount due. Communicates eligibility changes and member updates to carrier and works through reconciliations.

Action	Contact Type	Contact Information
☐ Add ☐ Remove ☐ Update	Check all that apply: ☐ Group Administrator ☐ *† Employer Center ☐ Billing	Name: Title: Phone (area code required): Ext. Email:
☐ Add ☐ Remove ☐ Update	Check all that apply: ☐ Group Administrator ☐ *† Employer Center ☐ Billing	Name: Title: Phone (area code required): Ext. Email:
☐ Add ☐ Remove ☐ Update	Check all that apply: ☐ Group Administrator ☐ *† Employer Center ☐ Billing	Name: Title: Phone (area code required): Ext. Email:

SECTION D – ACKNOWLEDGMENT

I request the above-described changes on behalf of the group. Requested changes will not become effective unless approved in writing by Blue Cross Blue Shield of North Dakota (BCBSND). Approval may be for an effective date other than the requested effective date entered above, but any change of effective date will be specified in writing. If approved in writing by BCBSND, the approved request shall operate to amend the group's Group Master Application as of the effective date assigned by BCBSND, but shall amend that Group Master Application only as is necessary to effectuate the requested and approved change. All other terms of the Group Master Application shall remain in force. If any requested change is approved, the group should retain a copy of this BCBSND Renewal and Maintenance Change Request form for the group's records.

Group Authorized Representative Signature

Group Signature Date

Group Authorized Representative (print name)

Official Title

BCBSND Authorized Representative Signature

BCBSND Signature Date

Blue Cross Blue Shield of North Dakota: 4510 13th Avenue South, Fargo, ND 58121

