



**Arkansas
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

BlueCare Dental Change Request Form

Return To: Arkansas Blue Cross, Attn: Change Request, P.O. Box 2181, Little Rock, AR 72203-2181

1 CURRENT POLICYHOLDER INFORMATION:

Member ID: _____ Group Number: _____ Date of Birth: ___/___/___

First Name: _____ M.I.: _____ Last Name: _____

Primary Phone Number: _____ Alternate Phone Number: _____

CHANGES TO BE MADE

Please skip sections that do not apply to the change(s) you are making.

2 ADDRESS CHANGES:

Residential Address: Street _____
City _____ State _____ Zip _____

Mailing Address: Street _____
City _____ State _____ Zip _____

Billing Address: Street _____
City _____ State _____ Zip _____

3 NAME CHANGE:

From: First Name _____ M.I. _____ Last Name _____

To: First Name _____ M.I. _____ Last Name _____

Is this name change as a result of a marriage? Yes No Marriage Date ___/___/___

Is this name change as a result of a divorce? Yes No Divorce Date ___/___/___

Other reason for change: _____ Date of Change ___/___/___

4 BILLING CHANGE:

- Monthly Bank Draft (must attach a completed Pre-Authorized Bank Draft Form and voided check)
 Quarterly Invoice Semi-Annual Invoice Annual Invoice

5 DELETE PERSON(S) FROM THE POLICY:

| Last Name | First Name | M.I. | Date of Birth | Reason Code* (see below) | Date of Change |
|-----------|------------|------|---------------|-----------------------------|----------------|
| | | | | | |
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| | | | | | |
| | | | | | |

*Reason Codes: 1-Divorce 2-Student Status Change 3-Aging Off 4-Marriage 5-Death 6-Other

6 OWNERSHIP CHANGE:

From: First Name _____ M.I. _____ Last Name _____

To: First Name _____ M.I. _____ Last Name _____

7 SPLIT POLICY:

Indicate the name of the covered person(s) you want covered on a separate policy with identical coverage.

| Last Name | First Name | M.I. | Date of Birth | Reason Code* (see below) | Date of Change |
|-----------|------------|------|---------------|-----------------------------|----------------|
| | | | | | |
| | | | | | |
| | | | | | |

*Reason Codes: 1-Divorce 2-Student Status Change 3-Aging Off 4-Marriage 5-Other (specify above)

Please provide Address Information for new Policyholder ONLY:

Residential Address: Street _____

City _____ State _____ Zip _____

Mailing Address: Street _____

City _____ State _____ Zip _____

Billing Address: Street _____

City _____ State _____ Zip _____

Please set up the billing mode for my new policy:

Monthly Bank Draft (must attach a completed Pre-Authorized Bank Draft Form and voided check)

Quarterly Invoice

Semi-Annual Invoice

Annual Invoice

8 PLEASE CHANGE MY PLAN TYPE:

Individual

Individual and Spouse

Individual and Child(ren)

Family

Please add the following dependent(s):

IMPORTANT NOTE: Children age 19 and/or older must apply on their own.

| Last Name | First Name | M.I. | Sex | Date of Birth | S.S. Number | Relationship |
|-----------|------------|------|-----|---------------|-------------|--------------|
| | | | | | | |
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| | | | | | | |

Do all dependents listed above live in the same household? Yes No

If no, provide reason: _____

Address: _____

Do all dependents listed above live in Arkansas? Yes No

Have any of the proposed insureds had Blue Care Dental within the last 12 months? Yes No

If yes, termination dates: ____/____/____

Member ID _____

PLEASE READ BEFORE SIGNING:

I UNDERSTAND: (1) This application may be rejected. (2) If accepted, the insurance applied for shall not become effective until the date shown on my schedule of benefits and the adjusted premium, if applicable, is paid in full. (3) If my application is accepted relying on my representations on this document, any coverage which may be issued to me shall be invalid if based on false information. (4) My signature authorizes Arkansas Blue Cross and Blue Shield to coordinate benefits under this policy with other insurance I have which is subject to coordination. (5) Arkansas Blue Cross and Blue Shield may phone me for additional information that may help with the timely processing of my application. In signing below, I represent that the statements and answers given in this application and any signed and dated addendum to this application are true, complete and correctly recorded.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Note: This application must be signed in the state of Arkansas.

| | | | |
|---|----------|----------------|--|
| Signature of CURRENT POLICYHOLDER (Parent/Guardian, if policy for a minor) | X | Date Signed | |
| Signature of NEW POLICYHOLDER | X | Date Signed | |

For Home Office Endorsements:

Pre-Authorized Bank Draft

Monthly Program Sign-up Form

Our monthly bank draft service makes premium payments easy and convenient for you. Just a few steps now helps assure your payments are made accurately and timely. Signing up is as easy as 1, 2, 3:

1. Complete the information below.
2. Attach a **VOIDED** check from the bank account to be drafted.
3. Mail this completed authorization form and the voided check to:

Arkansas Blue Cross and Blue Shield
Attn: Cashiers (Drafts)
P.O. Box 3590
Little Rock, AR 72203

Important: Please Read Before Signing

I authorize Arkansas Blue Cross and Blue Shield, a Mutual Insurance Company, and/or USABLE Life, and the BANK indicated above, to debit my Arkansas Blue Cross and/or USABLE Life premium from my checking or savings account indicated above. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such time and manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) days' written notice of the BANK's termination of this agreement.

I understand that by revoking the Pre-Authorized Bank Draft Program after I have agreed to it, I also will be terminating my Arkansas Blue Cross and/or USABLE Life coverage, UNLESS Arkansas Blue Cross and/or USABLE Life has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorized Bank Draft Program withdrawal date.

Insured(s) Information

First Name _____ Last Name _____

Address _____

Street

Apt. No

City

State

Zip

Please check one of the following

Currently, the insured's premium is **not** drafted

Currently, the insured's premium is drafted and the account information has changed

Bank Account Information

Bank Name _____

Name on Account _____

(If different than the proposed)

Routing Number _____

Account Number _____

Type of Account: Checking Savings

Attach VOIDED check HERE

Signature

Signature _____ Date _____

Signature of Bank Holder

After Arkansas Blue Cross and Blue Shield receives and processes this completed authorization form, you will receive a letter providing the effective date of your first scheduled draft. We hope you find this bank draft service of value. It is our privilege to serve you. Thank you for your business!

For Office Use Only (please do not write in this space)

| ID NO. | EFFECTIVE DATE |
|--------|----------------|
| | |



**Arkansas
Blue Cross Blue Shield**

An Independent Licensee of the Blue Cross and Blue Shield Association

USABLE Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USABLE Life does not sell or service Arkansas Blue Cross and Blue Shield products. USABLE Life is solely responsible for the term life and critical illness policies referenced in your policy.

