



**Arkansas
BlueCross BlueShield**
An Independent Licensee of the Blue Cross and Blue Shield Association

Individual/Family Health Insurance Non-Underwriting Change Form

**Before completing this Change Form,
please read the following instructions:**

- This form is a legal document. It is very important that you provide **all** requested information and that it is accurate and legible.
- Please ensure that all required parties sign and date the form.
- This form must be completed in dark blue or black ink.
- If you make a mistake, please mark through the incorrect information, initial it and then provide the correct information.
- Any attached sheets must be signed and dated.
- **We strongly encourage you to make a photocopy of this completed form for your records.**

good for
you.



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Non-Underwriting Change Form For Current Policy

Return To: Arkansas Blue Cross and Blue Shield, 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: _____

2 CONTACT INFORMATION

| | | | |
|---------------------------------|-----------------------------------|----------------------------|----------------|
| Primary Phone Number () () | Alternate Phone Number () () | Best Time to Call AM PM | E-Mail Address |
|---------------------------------|-----------------------------------|----------------------------|----------------|

CHANGES TO BE MADE

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

3 ADDRESS CHANGES

Residential Address: Street _____
City _____ State _____ Zip _____
Mailing Address: Street _____
City _____ State _____ Zip _____
Billing Address: Street _____
City _____ State _____ Zip _____

4 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 ____/____/____

5 BILLING CHANGE

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

6 DELETE PERSON(S) FROM THE POLICY

| 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-Death 6-Other

7 OWNERSHIP CHANGE

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

8 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

9 DELETE BENEFITS

Term Life Insurance

Maternity Rider

10 BENEFIT CHANGES

IMPORTANT NOTE: Increasing the calendar-year deductible means that any claims processed by Arkansas Blue Cross after the effective date of change, regardless of the date of the service(s), will be applied to the new higher deductible.

▲ ACCESS BLUE PPO (Group # 700101-700104 or 700201-700204)

Increase My Calendar-Year Deductible To:

\$1,000

\$2,500

▲ BASIC BLUE PPO (Group # 710000 or 720000)

Delete the following Benefit:

Physician Office Visits Rider

Prescription Drugs Rider

▲ BLUECARE PPO (Group # 600010-600016 or 600020-600026)

BLUECARE PPO PLUS (Group # 600030-600036 or 600040-600046)

Increase My Calendar-Year Deductible To:

\$1,000

\$1,500

\$2,500*

Increase My Calendar-Year Coinsurance Maximum To:

\$5,000

*\$2,500 has no coinsurance maximum

10 BENEFIT CHANGES (continued)

IMPORTANT NOTE: Increasing the calendar-year deductible means that any claims processed by Arkansas Blue Cross after the effective date of change, regardless of the date of the service(s), will be applied to the new higher deductible.

▲ BLUECHOICE (Group # 771000-771023 or 781000-781020)

Increase My Calendar-Year Deductible and Benefit To:

\$500 Deductible Options

- \$1,000 OOP* coinsurance maximum and EC Rx plan
- \$2,000 OOP* coinsurance maximum and CC Rx plan
- \$2,000 OOP* coinsurance maximum and EC Rx plan

\$1,000 Deductible Options

- \$1,000 OOP* coinsurance maximum and CC Rx plan
- \$1,000 OOP* coinsurance maximum and EC Rx plan
- \$2,000 OOP* coinsurance maximum and CC Rx plan
- \$2,000 OOP* coinsurance maximum and EC Rx plan

\$2,500 Deductible Options

- No OOP* coinsurance and CC Rx plan
- No OOP* coinsurance and EC Rx plan
- \$2,000 OOP* coinsurance maximum and CC Rx plan
- \$2,000 OOP* coinsurance maximum and EC Rx plan

*Out-of-Pocket

\$5,000 Deductible Options

- \$30/\$50 copay and CC Rx plan
- \$30/\$50 copay and EC Rx plan
- No physician copays** and CC Rx plan
- No physician copays** and EC Rx plan

\$10,000 Deductible Options

- \$30/\$50 copay and CC Rx plan
- \$30/\$50 copay and EC Rx plan
- No physician copays** and CC Rx plan
- No physician copays** and EC Rx plan

\$25,000 Deductible Options

- \$30/\$50 copay and CC Rx plan
- \$30/\$50 copay and EC Rx plan
- No physician copays** and CC Rx plan
- No physician copays** and EC Rx plan

**Physician visits subject to deductible.

▲ BLUE SELECT (Group # 601000-601007 or 602000-602007)

Increase My Calendar-Year Deductible To: \$1,000 \$1,500 \$2,500
Increase My Calendar-Year Coinsurance Maximum To: \$5,000
Delete the following Benefit: SAE – Supplemental Accident Endorsement

▲ BLUE SOLUTION (Group # 770000-770003 or 780000-780003)

Increase My Calendar-Year Deductible To: \$1,500 \$3,000 \$5,000

▲ COMPREHENSIVE BLUE PPO (Group # 790000-790007 or 700000-700007)

COMPREHENSIVE BLUE PPO II (Group # 791000-795000 or 701000-705000)

Increase My Calendar-Year Deductible To: \$1,000 \$2,500 \$5,000 \$10,000
Delete the following Benefit: Mental Health Parity Rider

▲ CONVERSION (Group # 902100-902140)

Increase My Calendar-Year Deductible and Benefit To:

- \$ 500 Deductible, 80/20% Coinsurance, \$5,000 Calendar-Year Coinsurance Maximum
- \$1,000 Deductible, 80/20% Coinsurance, \$5,000 Calendar-Year Coinsurance Maximum
- \$1,000 Deductible, 80/20% Coinsurance, No Calendar-Year Coinsurance Maximum

▲ HSA BLUE PPO (Group # 730000-730021 or 740000-740021)

HSA BLUE PPO PLUS (Group # 750000-750021 or 760000-760021)

Increase My Calendar-Year Deductible To:

- \$3,000 Individual/\$5,950 Family Deductible, 0% Coinsurance, No Calendar-Year Coinsurance Maximum
- \$3,000 Individual/\$5,950 Family Deductible, 80/20% Coinsurance, \$10,000 Individual/\$20,000 Calendar-Year Coinsurance Maximum
- \$5,800 Individual/\$11,600 Family Deductible, 0% Coinsurance, No Calendar-Year Coinsurance Maximum

10 BENEFIT CHANGES (continued)

IMPORTANT NOTE: Increasing the calendar-year deductible means that any claims processed by Arkansas Blue Cross after the effective date of change, regardless of the date of the service(s), will be applied to the new higher deductible.

▲ HSA BLUE PPO II (Group # 711000-711005 or 722000-722005)

Increase My Calendar-Year Deductible To: \$2,500 Individual/\$5,000 Family Deductible
 \$5,000 Individual/\$10,000 Family Deductible

▲ **UNIQUECARE** (Group # 610100-611000, 620100-621000 or 650100-651000, 660100-661000)
UNIQUECARE BLUE (Group # 600100-600114, 600200-600214 or 600300-600311, 600400-600410)
UNIQUECARE BLUE PREFERRED (Group # 622001-622016, 633001-633016
or 622017-622024, 633017-633025)
FARM BUREAU FLEXPLAN (Group # 809031-809046 or 809047-809058)
FARM BUREAU FLEXPLAN PREFERRED (Group # 808001-808027 or 808004-808028)

Increase My Calendar-Year Deductible and Benefit To:

Deductible: \$1,000 \$2,500 \$5,000 \$10,000 \$25,000

Choice of Plan: Plan B: 80/20% Coinsurance Plan C: 50% Coinsurance

Calendar-Year Coinsurance Maximum: \$10,000 \$50,000

Delete the following Benefit: SAE – Supplemental Accident Endorsement

11 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 (both front and back) 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.

I certify that I signed this change form in the state of Arkansas.

SIGNATURE SECTION (Please sign appropriate line only)

| | | |
|------------------------------------------------------------------------------------|----------|-------------|
| 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

THIS APPLICATION IS VALID FOR 90 DAYS ONLY WHEN COMPLETED AND SIGNED.

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 |
|--------|----------------|
| | |

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.



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Form No. Non-UndChg Form (R12/09)



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P.O. Box 2181, Little Rock, AR 72203-2181
www.ArkansasBlueCross.com