



## ***Individual/Family Health Insurance Non-Underwriting Change Form***

**READ ALL INSTRUCTIONS BEFORE COMPLETING THIS CHANGE FORM. CHANGE FORM MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.**

- This form is a legal document. If you are approved for coverage, it will become a part of your contract. Therefore, all information provided must be accurate and legible.
- This change form must be completed in dark blue or black ink. Forms completed in **pencil** will not be accepted.
- If you make a mistake, mark through the incorrect information, initial it, date it, and provide the correct information.
- Do not use liquid paper, correction tape, or “white out” to correct any mistakes on this form.
- Any **attachments** submitted with the change form must be signed and dated.
- **Do not send any money with this change form.**
- Please ensure all required parties have signed and dated the change form prior to submission.
- **We strongly recommend you make a copy of this completed change form for your records.**

### **\*\*IMPORTANT INFORMATION REGARDING GRANDFATHERED PLANS\*\***

Your Arkansas Blue Cross and Blue Shield coverage **may** be a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Arkansas Blue Cross and Blue Shield Customer Service at 1-800-238-8379. You may also contact the U.S. Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov).

## INSTRUCTION SHEET

**Changes to your policy can only be made during the annual open enrollment period, unless the change is a result of a qualifying life event, such as birth of a child, adoption, loss of other coverage, marriage, etc.**

**When you are completing this form, please refer to your Arkansas Blue Cross and Blue Shield identification card for your Member ID and Group #. This information must be entered correctly under Section 1 in order to process your request.**

**Effective Date:** The effective date for any changes requested from a “qualifying life event” will be the next available effective date following approval. Changes requested during the annual open enrollment period will become effective the following January (the 1<sup>st</sup> or 15<sup>th</sup> of the month, depending on your billing date).

**Billing Change:** Any request made to change your billing will be based on the current billing date of your policy.

### Section 3 – Address Changes

Any change to your current address information can be completed in **Section 3 – Address Changes**. We have provided three separate listings for this information. Only complete for addresses that are changing.

**Residential** – This address will be noted as your physical place of residence.

**Mailing** – Correspondence such as letters and Explanations of Benefits (EOBs) will be mailed to this address.

**Billing** – All billing invoices will be mailed to this address.

### Section 5 – Name Change

Documentation is required for any name change request. Please complete **Section 5 – Name Change** and attach appropriate documentation such as, a copy of your Marriage License, Divorce Decree, Adoption papers or other court papers to support the change.

### Section 7 – Delete Person(s) From The Policy

Qualifying life event changes allow you to make changes to your policy outside of the annual open enrollment period. Such events include, but are not limited to (**please ensure all documentation is included**):

- Divorce/Legal Separation (requires a copy of divorce decree/legal separation)
- No longer an Arkansas resident (requires a date of move or date of notification)
- Marriage (requires a copy of the marriage certificate)
- Becoming eligible for other coverage (requires proof of eligibility of other coverage)
- Death (requires a copy of death certificate)

In the event you would like to **terminate coverage** for a covered person, including the policyholder, you can do so by completing **Section 7 – Delete Person(s) From The Policy**.

**OR**

You have the option to **maintain the person’s coverage** by splitting him/her off onto a new individual policy with identical coverage. This will completely remove him/her from your coverage and create a new policy for the covered person. You can make this change by completing **Section 9 – Split Policy**. A signature is **required** by **both** the current policyholder and new policyholder. **Important Note:** Complete one change form for each new policy you are requesting.

### Section 8 – Ownership Changes

If both the policyholder and spouse are retaining coverage, but you would like to change the ownership of the policy from the current policyholder to the spouse, complete **Section 8 – Ownership Change**. Both the current policyholder and new policyholder must sign the change form.

### Section 11 – Benefit Changes

- This section reflects all benefit options available for your policy.
- Please complete **only** the section for your specific policy.
- If you are unsure of your product name, use the product group numbers listed as a reference. Your product group number can be found on your identification card under **Group #**. It will be the first six numbers before the dash.
- If you still have questions, call customer service at **1-800-238-8379**.



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

# 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  
or Fax to: 501-378-3248

## 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	How do you prefer we communicate with you? <input type="checkbox"/> E-mail <input type="checkbox"/> Phone
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### 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 POLICY CHANGE ELIGIBILITY

Check all applicable boxes below that support your change request.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> 1-Annual Open Enrollment Period | <input type="checkbox"/> 6-Divorce or Legal Separation                             | <input type="checkbox"/> 9-Involuntary loss of other health coverage |
| <input type="checkbox"/> 2-Birth                         | <input type="checkbox"/> 7-New Guardianship/Legal custody/court order to add child | <input type="checkbox"/> 10-Military Leave                           |
| <input type="checkbox"/> 3-Adoption                      | <input type="checkbox"/> 8-Loss of employer-sponsored health coverage              | <input type="checkbox"/> 11-Military Reinstatement                   |
| <input type="checkbox"/> 4-Death                         |  | <input type="checkbox"/> 12-Other (Give specific details) _____      |
| <input type="checkbox"/> 5-Marriage                      |  | _____  |

NOTE: If Change Form is **not** received during Open Enrollment Period, you must submit appropriate documentation with Change Form to confirm qualifying life event (i.e. copy of birth or death certificate, copy of marriage license, Certificate of Creditable Coverage from previous insurance company, guardianship/custody documentation, etc.)

## 5 NAME CHANGE

Additional documentation required. Read instructions for Section 5 before completing.

From: First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_  
To: First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

## 6 BILLING CHANGE

- Monthly Bank Draft (Must complete attached bank draft form)  Quarterly Invoice  Semi-Annual Invoice  Annual Invoice

## 7 DELETE PERSON(S) FROM THE POLICY

First Name	M.I.	Last Name	Suffix	Date of Birth

## 8 OWNERSHIP CHANGE

From: First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_  
To: First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

## 9 SPLIT POLICY

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

First Name	M.I.	Last Name	Suffix	Date of Birth

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

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       Quarterly Invoice       Semi-Annual Invoice       Annual Invoice  
(Must complete attached bank draft form)

## 10 DELETE BENEFITS (see Products in section 11 for other optional riders)

Term Life Insurance     Maternity Rider       Mental Health Parity  
(Only applicable for Comprehensive Blue PPO and Comprehensive Blue PPO II)

## 11 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.

**▲ AccessBlue PPO Group # 700101-700104 or 700201-700204 - Grandfathered**

Increase my calendar-year deductible to:       \$1,000       \$2,500

**▲ AccessBlue PPO Group # 300101-300104 or 300201-300204 - Non-Grandfathered**

Increase my calendar-year deductible to:       \$1,000       \$2,500

**▲ Basic Blue PPO Group # 710000 or 720000 - Grandfathered**

Delete the following benefit:       Physician Office Visits Rider       Prescription Drugs Rider

**▲ BlueCare PPO Group # 600010-600016 or 600020-600026 - Grandfathered**

**BlueCare PPO Plus Group # 600030-600036 or 600040-600046 - Grandfathered**

Increase my calendar-year deductible to:       \$1,000       \$1,500       \$2,500\*

Increase my calendar-year coinsurance maximum to:       \$2,000

\*\$2,500 has no coinsurance maximum

## 11 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.

### ▲ **Blue Choice** Group # 771000-771023 or 781000-781020 - Grandfathered

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 - Grandfathered

Increase my calendar-year deductible to:  \$1,000  \$1,500  \$2,500

Increase my calendar-year coinsurance maximum to:  \$2,000

Delete the following benefit:  SAE – Supplemental Accident Endorsement

### ▲ **Blue Solution** Group # 770000-770003 or 780000-780003 - Grandfathered

Increase my calendar-year deductible to:  \$1,500  \$3,000  \$5,000

### ▲ **Comprehensive Blue PPO** Group # 790000-790007 or 700000-700007 - Grandfathered

#### **Comprehensive Blue PPO II** Group # 791000-798000 or 701000-708000 - Grandfathered

Increase my calendar-year deductible to:  \$1,000  \$2,500  \$5,000  \$10,000

#### **Comprehensive Blue PPO** Group # 300000-300007 or 390000-390007 - Non-Grandfathered

#### **Comprehensive Blue PPO II** Group # 391000-398000 or 301000-308000 - Non-Grandfathered

Increase my calendar-year deductible to:  \$1,000  \$2,500  \$5,000  \$10,000

### ▲ **Comprehensive Blue PPO III** Group # 700008-700016 or 790008-790016

Increase my calendar-year deductible to:  \$1,500  \$2,500  \$5,000  \$7,500  
 \$10,000  \$15,000  \$20,000  \$25,000

### ▲ **Conversion** Group # 902100-902140 - Grandfathered

#### **Conversion** Group # 302100-302140 - Non-Grandfathered

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 - Grandfathered

#### **HSA Blue PPO Plus** Group # 750000-750021 or 760000-760021 - Grandfathered

Increase my calendar-year deductible to:

- \$3,100 Individual/\$6,250 Family Deductible, 0% Coinsurance, No Calendar-Year Coinsurance Maximum
- \$3,100 Individual/\$6,250 Family Deductible, 80/20% Coinsurance, \$10,000 Individual/\$20,000 Calendar-Year Coinsurance Maximum
- \$6,050 Individual/\$12,100 Family Deductible, 0% Coinsurance, No Calendar-Year Coinsurance Maximum

**11 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 - Grandfathered**

Increase my calendar-year deductible to:  \$2,500 Individual/\$5,000 Family Deductible  
 \$5,000 Individual/\$10,000 Family Deductible

**HSA Blue PPO II Group # 311000-311005 or 322000-322005 - Non-Grandfathered**

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, or 660100-661000 - Grandfathered**
- Uniquecare Blue Group # 600100-600114, 600200-600214 or 600300-600311, or 600400-600410 - Grandfathered**
- Uniquecare Blue Preferred Group # 622001-622016, 633001-633016 - Grandfathered**
- Farm Bureau Flexplan Group # 809031-809046 - Grandfathered**
- Farm Bureau Flexplan Preferred Group # 808001-808027 or 808004-808028 - Grandfathered**

**Increase my calendar-year deductible and benefit to:**

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

\*Not available with Plan A (100% Coinsurance)

Choice of Plan:  Plan A: 100%\*\* Coinsurance  Plan B: 80/20% Coinsurance  Plan C: 50% Coinsurance  
 \*\*Coinsurance Maximum amount not applicable

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

NOTE: Your coinsurance maximum must be greater than your deductible.

**Delete the following Benefit:** SAE – Supplemental Accident Endorsement

**PLEASE READ BEFORE SIGNING**

I understand: (1) This application may be rejected if the applicant is age 19 or older. (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 in this document, any coverage which may be issued to me shall be invalid if based on intentional misrepresentations of material fact or fraud. (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.

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

**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.**

**SIGNATURE SECTION (Please sign appropriate line only)**

Current Policyholder <b>OR</b> Parent Legal/Guardian's (if policy for a minor)	(Please Print) <b>X</b>	Date Signed
	(Please Sign) <b>X</b>	
New Policyholder	<b>X</b>	Date Signed

**COMMENTS**

**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 help assure your payments are made accurately and timely.

1. Complete the information below.

### Important: Please Read Before Signing

2. Mail this completed authorization form to:

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

I authorize Arkansas Blue Cross and Blue Shield, USABLE Life, and the BANK indicated below, to debit my Arkansas Blue Cross and/or USABLE Life premium from my checking or savings account indicated below. 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.

I understand that an insufficient check fee will be assessed for any payment returned to Arkansas Blue Cross as a result of insufficient funds.

### Insured's Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_  
Street \_\_\_\_\_ Apt. No \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Arkansas Blue Cross and Blue Shield Member ID \_\_\_\_\_

Please check one of the following:

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

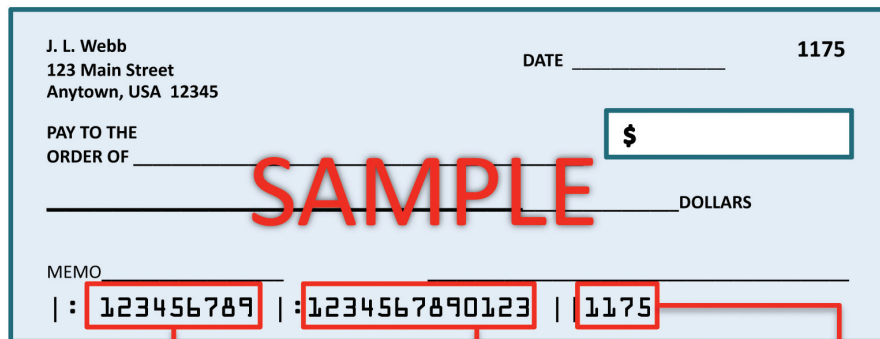
Currently, the insured's premium is drafted and the account information has changed

### Bank Account Information

Bank Name \_\_\_\_\_ Name on Account \_\_\_\_\_  
(If different than the insured)

Routing Number \_\_\_\_\_ Account Number \_\_\_\_\_

Type of Account:  Checking  Savings



Bank Routing Number

Bank Account Number

Check Number

### Signature

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Bank Account Holder

After Arkansas Blue Cross 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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**Arkansas**  
**BlueCross BlueShield**  
P.O. Box 2181, Little Rock, AR 72203-2181