



Arkansas
BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

Individual/Family Health Insurance 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.**
- All increases in benefits are subject to underwriting approval. You **MUST** complete sections 9-21.

good for
you.



**Arkansas
BlueCross BlueShield**

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IMPORTANT:

We cannot process your application without this completed form.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, or other provider of health care services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any health care item or service in relation to the health care provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, 601 Gaines, Little Rock, AR 72203. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 *et seq.*, the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 *et seq.* and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 *et seq.* Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

| | | | |
|------------------------------------|---|--|------|
| Applicants age 18 and older | This authorization must be signed by each applicant age 18 or older. | | |
| | Print Name(s) | Signature | Date |
| | _____ | _____ | / / |
| | _____ | _____ | / / |
| | _____ | _____ | / / |
| | _____ | _____ | / / |
| Applicants under age 18 | List applicants under age 18 (Print Name). | | |
| | _____ | | |
| | _____ | | |
| | _____ | | |
| | _____ | | |
| | | Parent/Legal Guardian's Signature (if policy for a minor) | Date |



**Arkansas
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Underwriting Change Form For Current Policy

Return To:
Arkansas Blue Cross and Blue Shield, Attn: Individual Underwriting, 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 |
|---------------------------------|-----------------------------------|----------------------------|----------------|

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

IMPORTANT NOTE: You must complete sections 19 through 21. Please use the "Newborn/Adopted Child" Change Form only to request additions of a newborn and/or a newly adopted child.

3 POLICY APPEALS

- Request for Reinstatement _____
- Remove Tobacco Surcharge: Name _____ Date Quit ____/____/____
- Remove Non-Tobacco Surcharge: Name _____
- Remove Exclusion Rider: Name _____ Excluded Condition _____
- Other _____

4 ADD SPOUSE

| Last Name | First Name | M.I. | Sex | Birth Date | Social Security No. | Height | Weight | Date of Marriage |
|-----------|------------|------|-----|------------|---------------------|--------|--------|------------------|
| | | | | | | | | |

5 ADD DEPENDENT(S)

| Last Name | First Name | M.I. | Sex | Birth Date | Social Security No. | Height | Weight | Relationship |
|-----------|------------|------|-----|------------|---------------------|--------|--------|--------------|
| | | | | | | | | |
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6 STUDENT INFORMATION [Dependent(s) age 19 through 24]. Must be full-time student(s).

| Dependent | School Attending | Semester Hrs. | Est. Day of Graduation |
|-----------|------------------|---------------|------------------------|
| | | | |
| | | | |
| | | | |
| | | | |

7 ADD MATERNITY

Access Blue PPO (Not An Option)
Basic Blue PPO (Not An Option)
Conversion (Not Applicable)

- BlueCare PPO
- BlueCare PPO Plus
- Blue Choice
- Blue Select
 - \$2,000 \$3,000 \$5,000
- Blue Solution
- Comprehensive Blue PPO
- Comprehensive Blue PPO II

- HSA Blue PPO
- HSA Blue PPO Plus
- HSA Blue PPO II
- UniqueCare
- UniqueCare Blue
 - \$2,000 \$3,000 \$5,000
- UniqueCare Blue Preferred
- Farm Bureau FlexPlan
- Farm Bureau FlexPlan Preferred

8 BENEFIT CHANGES

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

Decrease My Calendar-Year Deductible To: \$500 \$1,000

▼ BASIC BLUE PPO (Group # 710000 or 720000)

Add 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)

Decrease My Calendar-Year Deductible To: \$500 \$1,000 \$1,500
Decrease My Calendar-Year Coinsurance Maximum To: \$5,000 \$10,000

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

Decrease My Calendar-Year Deductible and Benefit To:

\$500 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

\$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)

Decrease My Calendar-Year Deductible To: \$500 \$1,000 \$1,500
Decrease My Calendar-Year Coinsurance Maximum To: \$5,000

8 BENEFIT CHANGES (continued)

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

Decrease My Calendar-Year Deductible To: \$750 \$1,500 \$3,000

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

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

Decrease My Calendar-Year Deductible To: \$500 \$1,000 \$2,500
 \$5,000 \$10,000

▼ CONVERSION (Group # 902100-902140)

Decrease My Calendar-Year Deductible and Benefit To:

- \$ 100 Deductible, 80/20% Coinsurance, \$5,000 Calendar-Year Coinsurance Maximum
 \$ 500 Deductible, 80/20% Coinsurance, \$5,000 Calendar-Year Coinsurance Maximum
 \$1,000 Deductible, 80/20% Coinsurance, \$5,000 Calendar-Year Coinsurance Maximum

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

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

Decrease My Calendar-Year Deductible and Benefit To:

- \$1,150 Individual/\$2,300 Family Deductible, 80/20% Coinsurance, \$10,000 Individual/\$20,000 Family Coinsurance Maximum
 \$3,000 Individual/\$5,950 Family Deductible, 80/20% Coinsurance, \$10,000 Individual/\$20,000 Family Coinsurance Maximum
 \$3,000 Individual/\$5,950 Family Deductible, 0% Coinsurance, No Calendar-Year Coinsurance Maximum

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

Decrease My Calendar-Year Deductible To: \$1,500 Individual/\$3,000 Family Deductible
 \$2,500 Individual/\$5,000 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)

Decrease My Calendar-Year Deductible and Benefit To:

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

*Not available with Part A (100%)

Choice of Plan: Plan A: 100%* Coinsurance Plan B: 80/20% Coinsurance

*Coinsurance Maximum amount not applicable

Calendar-Year Coinsurance Maximum: \$2,500 \$10,000

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

9 HOUSEHOLD INFORMATION

- Yes** **No** a. Do all applicants reside in the same household?
If "No," please provide: Name _____ Reason: _____
- Yes** **No** b. Do all applicants reside in Arkansas?
If "No," please provide: Name _____ Reason: _____

10 APPLICANT(S) EMPLOYMENT INFORMATION [applicant(s) age 18 and older]

Name _____ Employer _____
Job Duties _____

Name _____ Employer _____
Job Duties _____

11 CURRENT INSURANCE INFORMATION

- Yes** **No** a. Will the coverage applied for replace or change current hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant?
b. If "Yes," and the **coverage** has a specified termination date, please provide it here: ____/____/____
- Yes** **No** c. Will **any** applicants be **continuing** any other health insurance?
- Yes** **No** d. Are any applicants covered by Medicare? If "Yes," please provide name(s) below:
Name _____
Name _____
- Yes** **No** e. Are any applicants covered by Medicaid? If "Yes," reason for coverage: Financial Medical
please provide name(s) below:
Name _____
Name _____

12 DRIVER'S LICENSE INFORMATION [applicant(s) age 15 and older]

Name _____ License No. _____ State _____

Name _____ License No. _____ State _____

Name _____ License No. _____ State _____

In the past 5 years, has any applicant:

- Yes** **No** a. Had his or her driver's license suspended or revoked?
- Yes** **No** b. Had two or more moving traffic violations in the past five (5) years?
- Yes** **No** c. Been convicted or charged with driving under the influence of alcohol or a controlled substance?

If you answered "Yes," to any of the above questions, you **MUST** provide the following information:

Name _____ Date ____/____/____ Violation(s) _____

Name _____ Date ____/____/____ Violation(s) _____

13 SPORTING OR HOBBY INFORMATION

- Yes** **No** Does any applicant intend to pilot a private aircraft; race a motor vehicle, boat or snowmobile; or participate in sky or scuba diving, ballooning, mountain climbing, hang gliding or any other hazardous sport, hobby or activity?

Name _____ Please explain: _____

Name _____ Please explain: _____

14 TRAVEL OUTSIDE THE USA

- Yes** **No** Is any applicant planning to travel or work outside the USA within the next two years?

If "Yes," please provide the following:

Name (list **all** that apply) _____

Country _____ Expected Length of Stay _____ Departure date _____ Return date _____

Reason for Travel _____

15 EXPECTANT/ADOPTIVE PARENT INFORMATION

- Yes** **No** Is any **male** applying for coverage an expectant parent or a potential adoptive parent?
- Yes** **No** Is any **female** applying for coverage pregnant or a potential adoptive parent? If "Yes," please provide the following:
 Name _____ Expected Delivery/Adoption Date ____/____/____

16 INFERTILITY

- Has any applicant or spouse of a proposed applicant (**whether applying for coverage or not**):
- Yes** **No** a. Ever been diagnosed or treated for infertility?
- Yes** **No** b. Had surgical sterilization? If "Yes," please provide the following:
 Name _____ Procedure _____ Date ____/____/____
 Name _____ Procedure _____ Date ____/____/____

17 TOBACCO USAGE

- Yes** **No** Has any applicant to be covered used any form of tobacco within the last 12 months? If yes, list name of person(s) below and type and amount of tobacco used per day:
- Name _____ Type _____ Amount _____
 Name _____ Type _____ Amount _____
 Name _____ Type _____ Amount _____

18 PREVIOUS INSURANCE EXPERIENCE

- Yes** **No** Has any applicant ever been declined, rated, restricted or modified for the issue of life, accident, health or long-term care insurance? If "Yes," please provide the applicant(s) name and details:
- Name _____ Year _____ Details _____
 Name _____ Year _____ Details _____

19 PRESCRIPTION QUESTIONNAIRE

- Yes** **No** Is any proposed applicant **currently** taking any prescription medication, or has any applicant taken prescription medication in the **last 3 years**?
- If you answered "Yes," please provide full details below. Use separate sheet if necessary. **Any attachment must include all of the same information requested here and must be signed and dated.** A print out from the pharmacy is **not** acceptable. **Please use the name that would have been given at the time of the prescription — e.g., a maiden name may have been used.**

| Person Treated | Name of Drug | Dosage | Specific Condition or Illness | Start Date/ Stop Date | Degree of Recovery | | | Complete Name and Address of Physician |
|----------------|--------------|--------|-------------------------------|---------------------------|--------------------|---------|------|--|
| | | | | | None | Partial | Full | |
| | | | | ____/____/____ mo year | | | | |
| | | | | ____/____/____ mo year | | | | |
| | | | | ____/____/____ mo year | | | | |
| | | | | ____/____/____ mo year | | | | |
| | | | | ____/____/____ mo year | | | | |
| | | | | ____/____/____ mo year | | | | |

20 MEDICAL QUESTIONNAIRE

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.

For each question checked below, give full details in the **ADDITIONAL MEDICAL INFORMATION** section which follows.

1. Has any applicant **ever** had or been told he/she had: **(Each section must have at least one box checked.)**

A. BRAIN OR NERVOUS SYSTEM DISORDERS

- Alzheimer's disease or senile dementia
- Amyotrophic lateral sclerosis (Lou Gehrig's disease)
- Cerebral palsy
- Convulsions, epilepsy or seizures
- Meningitis
- Migraine headaches
- Multiple sclerosis, muscular dystrophy or myasthenia gravis
- Neuritis
- Paralysis or palsy
- Parkinson's disease
- Polyneuritis
- Vertigo, fainting or dizziness
- Any other disorder of the brain or nervous system
- None of the above apply to any applicant(s)**

B. CIRCULATORY

- Abnormal cholesterol/lipids
- Angina, heart attack, myocardial infarction
- Arteriosclerosis, coronary artery disease, shunt placement and/or angioplasty
- Cerebrovascular accident (stroke), including transient ischemic attack (TIA)
- Chest pain, shortness of breath, heart murmur, palpitation of the heart, rheumatic fever
- Heart bypass surgery, pacemaker implant
- Heart surgery
- High blood pressure
- Hemophilia
- Any other disorder of the heart, blood, blood vessels or circulatory system
- None of the above apply to any applicant(s)**

C. DIGESTIVE

- Cirrhosis
- Crohn's disease
- Gastric bypass surgery or other weight loss procedure
- Gastric or duodenal ulcer
- Hepatitis
- Hernia, hemorrhoids
- Irritable bowel syndrome or gastric esophageal reflux disorder (GERD)
- Pancreatitis
- Pyloric stenosis
- Ulcerative colitis
- Any other disorder of stomach, intestines, liver, gallbladder or rectum
- None of the above apply to any applicant(s)**

D. KIDNEY, URINARY, REPRODUCTIVE

- Abnormal pap smear
- Bladder or renal stones
- Cesarean section or miscarriage
- Dialysis
- Nephritis
- Nephrotic syndrome, renal disease or failure
- Sexually transmitted disease
- Sugar, blood or protein in urine
- Any other disorder of the kidneys or urinary tract
- Any other disorder of the male reproductive organs, including prostate
- Any other disorder of the female reproductive organs, including ovaries or breasts
- None of the above apply to any applicant(s)**

E. RESPIRATORY

- Allergies, asthma or bronchitis
- Chronic obstructive pulmonary disease
- Emphysema
- Lung disease
- Obstructive or reactive airway disorder
- Pleurisy
- Sleep apnea
- Any other disorder of the lungs, bronchial tubes or respiratory system
- None of the above apply to any applicant(s)**

F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS

- Anemia
- Cancer
- Hodgkin's disease
- Leukemia
- Malignancy of any kind
- Melanoma, neoplasm or tumor
- Any other disorder of the lymphatic system
- Any other disorder of the skin
- None of the above apply to any applicant(s)**

G. GLANDULAR DISORDERS

- Adrenal disorders
- Diabetes, abnormal glucose
- Goiter
- Any other disorder of the pancreas
- Any other disorder of the thyroid, pituitary, adrenal or other glands
- None of the above apply to any applicant(s)**

H. MUSCULOSKELETAL

- Arthralgia
- Arthritis
- Back pain
- Chronic fatigue
- Connective tissue disorder
- Fracture(s) or broken bone(s)
Exposed bone Yes No
- Fibromyalgia
- Gout
- Lupus, systemic
- Temporomandibular joint disorder (TMJ) or craniomandibular disorder
- Any other disorder of the muscles, bones or joints to include chiropractic care
- None of the above apply to any applicant(s)**

I. EAR/EYES/NOSE/THROAT

- Cataracts or glaucoma
- Meniere's disease
- Nasal septal defect
- Sinusitis, tonsillitis or otitis media
- Any other disorder of the eyes, ears, nose, throat or esophagus
- None of the above apply to any applicant(s)**

J. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE

- Anxiety, depression, emotional problems or nervous disorder
- Attempted suicide
- Counseling
- Drug overdose
- Eating disorder
- Psychiatric treatment
- Any other mental, emotional disorder or situation
- None of the above apply to any applicant(s)**

K. OTHER

- Current patient in a hospital or nursing home
- Sarcoidosis
- Breast implants
- Any other implant(s), prosthetic device(s), internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents)
- Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder or HIV
- Transplant recipient
- Any injury, deformity, incapacitation, disease or condition not listed elsewhere
- None of the above apply to any applicant(s)**

20 MEDICAL QUESTIONNAIRE (continued)

2. Has any applicant ever:

- Yes** **No** a. Consumed alcohol to excess, received treatment, or joined an organization for alcoholism or drug addictions?
- Yes** **No** b. Used any addictive or non-addictive drug or substance except as provided by a physician?
- Yes** **No** c. Required the assistance of any other individual for performances of any activities of daily living?
If "Yes," please explain: _____
- Yes** **No** d. Been told that he/she has or has had hearing problems, ear disorder(s) or has need of hearing devices due to any kind of hearing or ear impairment, or does any applicant have an existing hearing aid device in place?

ADDITIONAL MEDICAL INFORMATION

Give full details to questions answered affirmatively (checked or answered "Yes") to explain answers to questions 1A-K and 2. Under "Specific Condition/Illness and Type of Treatment" below, in addition to **condition/illness** please provide the **type of treatment** provided or planned – for example, surgery, X-rays, EKG, lab tests, hospitalization, emergency room visit, nursing home confinement, doctor visits, rehabilitation services, occupational therapy, physical therapy, speech therapy or chiropractic treatments. Please ensure you include **all** the treatments that apply. **Please use the name that would have been given at the time of the physician visit — e.g., a maiden name.**

| Question Number(s) | Person Treated | Specific Condition/Illness and Type of Treatment | Date of First Visit | Date of Last Visit | Total # of Visits | Degree of Recovery | | | Complete Name and Address of Physician |
|--------------------|----------------|--|---------------------|--------------------|-------------------|--------------------|---------|------|--|
| | | | | | | None | Partial | Full | |
| | | | / | / | | | | | |
| | | | mo year | mo year | | | | | |
| | | | | | | | | | |
| | | | / | / | | | | | |
| | | | mo year | mo year | | | | | |
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| | | | / | / | | | | | |
| | | | mo year | mo year | | | | | |

21 PRIMARY PHYSICIAN INFORMATION (Please provide for each applicant)

| Applicant's Name | Complete Name and Address of Physician | Date of Last Visit | Reason for Visit |
|------------------|--|--------------------|------------------|
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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.

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 |
| Spouse's Signature (required if applying) | X | Date Signed |
| Over Age 18 Dependent's Signature (required if applying) | X | Date Signed |

CUSTODIAL PARENT SIGNATURE SECTION

If any dependents named on this application do NOT reside with the proposed insured, the custodial parent's signature is required.

| | | |
|--|----------|---------------|
| Custodial Parent's Name and Address (please print) | X | Telephone No. |
| Custodial Parent's Signature | X | Date Signed |

THIS SECTION TO BE COMPLETED BY SALES REPRESENTATIVE

To the best of your knowledge, will the coverage applied for replace or change any existing hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant? Yes No

| | | |
|---|--|---------------|
| Sales Rep License # | Sales Representative's Name (Please Print) | Telephone No. |
| | X | |
| Agency Federal Tax ID # (If applicable) | Sales Representative's Signature | Date Signed |
| | X | |

FOR HOME OFFICE ENDORSEMENTS

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

Please keep for your records

Fair Credit Reporting Act Notice — Notice to Proposed Insured

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to Arkansas Blue Cross and Blue Shield. Your written request should be forwarded to Arkansas Blue Cross and Blue Shield, Individual Underwriting Division, P.O. Box 2181, Little Rock, Arkansas 72203-2181.



**Arkansas
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www.ArkansasBlueCross.com