



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

Dental Change Form

**BlueCare® Dental
DentalBlue®
DentalBlue® Plus Vision**

**Return To: Arkansas Blue Cross and Blue Shield, Attn: Change Request, P.O. Box 2181, Little Rock, AR 72203-2181
or Fax to: 501-378-2236**

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

5 DELETE PERSON(S) FROM THE POLICY

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

***Reason Codes:** 1 - Divorce 2 - Aging Off 3 - Marriage 4 - Death 5 - 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.

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

*Reason Codes: 1-Divorce 2-Aging Off 3-Marriage 4-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 Quarterly Invoice Semi-Annual Invoice Annual Invoice
(Must complete attached bank draft form)

8 CHANGE TYPE OF COVERAGE AND PLAN SELECTION

- Individual Individual and Spouse Individual and Child(ren) Individual/Spouse and Child(ren)

Please add the following dependent(s):

IMPORTANT NOTE: Children age 26 and older must apply on their own.

| First Name | M.I. | Last Name | Suffix | Relationship | Sex | Date of Birth | Social Security No. |
|------------|------|-----------|--------|--------------|-----|---------------|---------------------|
| | | | | | | | |
| | | | | | | | |

- Yes No Do all dependents listed above live in Arkansas?

If "no," please provide: Name: _____ Address: _____

Reason: _____

- Yes No Have any of the proposed insureds had any other dental coverage within the last 12 months?

If "yes," effective date: ____/____/____ Termination date: ____/____/____

Name of Company: _____ ID Number: _____

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.

I certify that I signed this application 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 OR Parent/Legal Guardian's (if policy for a minor) | X | Date Signed |
| New Policyholder (required if applying) | X | Date Signed |

For Home Office Use Only (Do not write in this space.)

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.
2. 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 and the BANK indicated below, to debit my Arkansas Blue Cross 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 coverage, UNLESS Arkansas Blue Cross 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

A sample check form with the following details:
Payor: J. L. Webb, 123 Main Street, Anytown, USA 12345
DATE: _____ 1175
PAY TO THE ORDER OF: _____ \$ _____
MEMO: _____
Routing Number: 123456789
Bank Account Number: 1234567890123
Check Number: 1175
The word "SAMPLE" is written in large red letters across the center of the check.

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!



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

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