

Individual/Family Health Insurance 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.

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 as a result of 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 1st or the 15th of the month, depending on your billing date).

SECTION 5 – U.S. CITIZENSHIP STATUS

- For any applicant who is not a U.S. citizen, a copy of his/her Permanent Resident VISA or green card issued by the U.S. Citizenship and Immigrant Services must be submitted with the application.
- Applicants must reside in the U.S. at least one year prior to being eligible to apply for coverage.
- Applicants who are not U.S. citizens will also be contacted by phone to complete a Foreign National Questionnaire.

SECTION 6 – ADDING SPOUSE OR DEPENDENT(S)

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:

- Obtaining guardianship, legal custody of a child, or court order requiring coverage for a dependent (requires proof of guardianship, legal custody or court order)
- Death of policyholder or covered member (requires a copy of death certificate)
- Loss of Eligibility (requires a Certificate of Creditable Coverage)
- Marriage (requires a copy of the marriage certificate)

SECTION 8 – BENEFIT CHANGES

- This section reflects all benefit options under 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**.

Detach and 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
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

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 or fax to 501-378-3752

1 CURRENT POLICYHOLDER INFORMATION

Member ID: _____ Group Number: _____ Date of Birth: ____/____/____
 First Name: _____ M.I.: ____ Last Name: _____ Social Security No.: _____
 Residential Address: _____ City: _____ State: ____ Zip: _____

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

Regardless of the change(s) you are requesting, you must complete sections 9-21.

3 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.)

4 POLICY APPEALS

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

5 U.S. CITIZENSHIP STATUS

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

- Yes No Are all applicants U.S. citizens? If "no," please provide the name(s) of the applicant(s) who are not U.S. citizens.

Name: _____ Name: _____

6 ADD SPOUSE OR DEPENDENT(S)

Read instructions for Section 6 before completing.

First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Security No.	Height	Weight
								__ ft. __ in.	__ lbs.
								__ ft. __ in.	__ lbs.
								__ ft. __ in.	__ lbs.
								__ ft. __ in.	__ lbs.

7 ADD MATERNITY

AccessBlue PPO (Not an option)

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

Basic Blue PPO (Not an option)

Conversion (Not applicable)

- 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

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

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

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

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

▲ Basic Blue PPO Group # 710000 or 720000 - Grandfathered

Add 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

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

Decrease my calendar-year coinsurance maximum to: \$1,000 \$2,000

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

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 - Grandfathered

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

Decrease my calendar-year coinsurance maximum to: \$1,000

8 BENEFIT CHANGES (continued)

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

Decrease my calendar-year deductible to: \$750 \$1,500 \$3,000

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

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

Decrease my calendar-year deductible to: \$500 \$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

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

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

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

▲ Conversion Group # 902100-902140 - Grandfathered

Conversion Group # 302100-302140 - Non-Grandfathered

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 - Grandfathered

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

Decrease my calendar-year deductible and benefit to:

- \$1,200 Individual/\$2,400 Family Deductible, 80/20% Coinsurance, \$10,000 Individual/\$20,000 Family Coinsurance Maximum
- \$3,100 Individual/\$6,250 Family Deductible, 80/20% Coinsurance, \$10,000 Individual/\$20,000 Family Coinsurance Maximum
- \$3,100 Individual/\$6,250 Family Deductible, 0% Coinsurance, No Calendar-Year Coinsurance Maximum

▲ HSA Blue PPO II Group # 711000-711005 or 722000-722005 - Grandfathered

Decrease my calendar-year deductible to: \$1,500 Individual/\$3,000 Family Deductible
 \$2,500 Individual/\$5,000 Family Deductible

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

Decrease my calendar-year deductible to: \$1,500 Individual/\$3,000 Family Deductible
 \$2,500 Individual/\$5,000 Family Deductible

▲ Uniqecare Group # 610100-611000, 620100-621000 or 650100-651000, 660100-661000 - Grandfathered

Uniqecare Blue Group # 600100-600114, 600200-600214 or 600300-600311, 600400-600410 - Grandfathered

Uniqecare 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

Decrease my calendar-year deductible and benefit to:

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

*Not available with Plan A (100% Coinsurance)

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: _____ Address: _____
Reason: _____
- Yes No b. Do all applicants reside in Arkansas? If "no," please provide:
Name: _____ Address: _____
Reason: _____

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

Name: _____ Employer: _____
Job Duties: _____

Name: _____ Employer: _____
Job Duties: _____

11 CURRENT INSURANCE COVERAGE

- 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?
i. If "yes," please provide name of carrier: _____
ii. If "yes," does the **coverage** have a specified termination date? If so, please provide date: ___/___/___.
- Yes No iii. If "yes," and the coverage does **not** have a specified termination date, will the coverage terminate if approved by Arkansas Blue Cross and accepted by the applicant?
- Yes No b. Have you recently lost employer-sponsored health coverage? If "yes," please provide:
Name: _____ Carrier Name: _____ Termination Date: ___/___/___.
Name: _____ Carrier Name: _____ Termination Date: ___/___/___.
- Yes No c. Have you recently "involuntarily" lost other health coverage? If "yes," please provide:
Name: _____ Carrier Name: _____ Termination Date: ___/___/___.
Name: _____ Carrier Name: _____ Termination Date: ___/___/___.
- Yes No d. Will any applicants be **continuing** any other health insurance? If "yes," please provide:
Name: _____ Carrier Name: _____ ID# _____
Name: _____ Carrier Name: _____ ID# _____
- Yes No e. Are any applicants covered by Medicaid (other than Women's Health/Family Planning coverage)? If "yes," please provide name(s) below:
Name: _____
Name: _____
- Yes No f. Are any applicants covered by Medicare? If "yes," please provide name(s) below:
Name: _____
Name: _____

12 DRIVER'S LICENSE INFORMATION [applicant(s) age 14 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?
- 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 father or a potential adoptive father?

Yes No Is any female applying for coverage pregnant or a potential adoptive mother?

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: _____ Treatment/Procedure: _____ Date: ____/____/____
 Name: _____ Treatment/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," please provide the following:

Name: _____ Type/Amount: _____ Date Last Used: ____/____/____
 Name: _____ Type/Amount: _____ Date Last Used: ____/____/____
 Name: _____ Type/Amount: _____ Date Last Used: ____/____/____

18 PREVIOUS INSURANCE EXPERIENCE

Yes No Has any applicant ever been declined, rated, restricted or modified for the issuance of life, accident, health or long-term care insurance? If "yes," please provide the following:

Name: _____ Carrier Name: _____ Year: ____ Details: _____
 Name: _____ Carrier 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 provide the name that would have been used at the time of the prescription (e.g., a maiden name may have been used.)

Person Treated	Name of Drug	Dosage	Specific Disorder or Illness	Start Date/ Stop Date	Degree of Recovery			Complete Name and Address of Prescribing Physician
					None	Partial	Full	
				____/____ mo year				
				____/____ 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. When multiple medical conditions are listed, please circle all conditions that apply.)**

A. BRAIN OR NERVOUS SYSTEM DISORDERS

- Alzheimer's disease or senile dementia
- Amyotrophic lateral sclerosis (Lou Gehrig's disease)
- Cerebral palsy
- Concussion or brain injury
- Convulsions, epilepsy or seizures
- Headaches or migraines
- Meningitis
- 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, atherosclerosis, coronary artery disease, stent placement or angioplasty
- Cerebrovascular accident (stroke), including transient ischemic attack (TIA)
- Chest pain, shortness of breath, heart murmur, palpitation of the heart, ablation, rheumatic fever
- Heart bypass surgery, pacemaker implant
- Heart or vein/artery surgery
- High blood pressure
- Hemophilia
- Valve repair/replacement
- 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 or ulcerative colitis
- 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
- 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 pulmonary disease, emphysema, lung disease or respiratory syncytial virus (RSV)
- Obstructive or reactive airway disorder
- Sleep apnea, cpap, bipap or vpap
- 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, leukemia or malignancy of any kind
- Hodgkin's or Non-Hodgkin's disease
- Melanoma, neoplasm or tumor
- Any other disorder of the lymphatic system
- Any disorder of the skin
- None of the above apply to any applicant(s)**

G. GLANDULAR DISORDERS

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

H. MUSCULOSKELETAL

- Arthritis, osteoarthritis, degenerative joint or disc disease
- Back pain and/or neck pain
- Chronic fatigue
- Connective tissue disorder
- Disease or disorder of the joints: knee(s), shoulder(s), elbow(s), wrist(s), other
- Fibromyalgia, bursitis or tendonitis

MUSCULOSKELETAL (cont.)

- Fracture(s) or broken bone(s)
Exposed bone Yes No
- Gout
- Lupus, systemic
- Temporomandibular joint disorder (TMJ/TMD) 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. EARS/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, insomnia, sleep disorder, depression, emotional problems or nervous disorder
- Attempted suicide
- Counseling or psychiatric treatment (in-patient or out-patient)
- Bipolar disorder, obsessive compulsive disorder or developmental disorder
- Eating disorder
- Any other mental, emotional disorder or situation, including ADD/ADHD
- None of the above apply to any applicant(s)**

K. OTHER

- Current patient in a hospital or nursing home
- Pending Surgery Surgery Date: __/__/__
- Sarcoidosis
- Breast implants
 Saline Silicone Surgery Date: __/__/__
- 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 for purposes other than recommended by your physician?
 Yes No c. Been treated for, diagnosed by or consulted a physician, psychotherapist, counselor or any other provider, or had any indication(s) of having a drug dependency/habit?
 Yes No d. Required the assistance of any other individual for performances of any activities of daily living? If "Yes," please explain: _____
 Yes No e. 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 in SECTION 20. 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 Disorder/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					
			mo / year	mo / year					
			mo / year	mo / year					
			mo / year	mo / year					

21 PHYSICIAN INFORMATION (Please provide for each applicant for the last five years)

Applicant's Name	Complete Name and Address of Physician	Date of Last Visit*	Reason for Visit**	Treatment/Results**

*Please write **NO VISIT** in this box if the applicant has never seen the physician. **Use "Comments" section on Page 8 if more room is needed for details.

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) Any members added to my policy will be subject to a 12-month pre-existing waiting period. This means conditions existing prior to the member's effective date of this policy will not be covered until his/her coverage has been in effect for 12 months. (5) 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. (6) 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 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 (required if policyholder is age 19 or older) OR Parent/Guardian's (if policy for a minor)	(Please Print) X (Please Sign) X	Date Signed
Spouse (required if applying)	X	Date Signed
Dependent age 18 or older (required if applying)	X	Date Signed

CUSTODIAL PARENT SECTION

If any applicant under age 19 (primary applicant or dependent), named on this application, does NOT reside with the proposed insured or the parent/guardian indicated in Section 2, the **custodial parent's** signature is also 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 No. (required)	Sales Representative's Name (Please Print) X	Telephone No.
Agency Federal Tax ID No. (if applicable)	Sales Representative's Signature X	Date Signed

COMMENTS

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



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, pharmacy benefits manager, 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. I understand that information re-disclosed may no longer be protected by federal privacy regulations. 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
BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 2181, Little Rock, AR 72203-2181