Dental Change Form

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

<table>
<thead>
<tr>
<th>First Name</th>
<th>M.I.</th>
<th>Last Name</th>
<th>Suffix</th>
<th>Date of Birth</th>
<th>Reason Code* (see below)</th>
<th>Date of Change</th>
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*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.

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<tr>
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<th>M.I.</th>
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<th>Suffix</th>
<th>Date of Birth</th>
<th>Reason Code* (see below)</th>
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*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.

<table>
<thead>
<tr>
<th>First Name</th>
<th>M.I.</th>
<th>Last Name</th>
<th>Suffix</th>
<th>Relationship</th>
<th>Sex</th>
<th>Date of Birth</th>
<th>Social Security No.</th>
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☐ 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. |

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<th>SIGNATURE SECTION (Please sign appropriate line only)</th>
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<tr>
<td><strong>Current Policyholder</strong></td>
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<tr>
<td><strong>OR</strong></td>
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<tr>
<td><strong>Parent/Legal Guardian's</strong></td>
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<tr>
<td><strong>(if policy for a minor)</strong></td>
</tr>
<tr>
<td><strong>New Policyholder</strong></td>
</tr>
<tr>
<td><strong>(required if applying)</strong></td>
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<td><strong>For Home Office Use Only (Do not write in this space.)</strong></td>
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</table>
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.

   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)

   Arkansas Blue Cross Blue Shield
   An Independent Licensee of the Blue Cross and Blue Shield Association

   Non-Under Dental Chg Fm (R01/12)
NOTICE: Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex.

We provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in various formats (large print, audio, accessible electronic formats, other formats), and language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact our Civil Rights Coordinator.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator  
601 Gaines Street, Little Rock, AR 72201  
Phone: 1-844-662-2276; TDD: 1-844-662-2275

You can file a grievance in person, by mail, or by email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201  
Phone: 1-800-368-1019; TDD: 1-800-537-7697


ATTENTION: Language assistance services, free of charge, are available to you. Call 1-844-662-2276.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-662-2276.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-662-2276.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-662-2276

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-662-2276 번으로 전화해 주십시오.

NOTICE 1557  09232016
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-662-2276.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-662-2276.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-662-2276.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-662-2276.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-662-2276.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-662-2276.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-662-2276.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-662-2276まで、お電話にてご連絡ください。


LALE: Ñe kwôj kômono Kajin Majôl, kwomaroñ bôk jerbal in jipañ ilo kajin ñe am ejełôk wôŋåan. Kaalôk 1-844-662-2276