



CHANGE REQUEST FORM FOR CURRENT POLICY

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IMPORTANT — COMPLETE ALL SECTIONS IN BLACK INK
PLEASE PRINT • SIGN AND DATE ON BACK

1 CURRENT POLICY INFORMATION (PLEASE USE LEGAL NAME):

LAST NAME		FIRST NAME		M.I.	BIRTH DATE	SEX	SOCIAL SECURITY NO.
STREET <input type="checkbox"/> NEW		COUNTY	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED			CURRENT ID #	
CITY	STATE	ZIP CODE	DAYTIME PHONE () _____		EVENING PHONE () _____		CURRENT GROUP #

CHANGE IN NAME OR COVERAGE OWNERSHIP:

IMPORTANT: If changing name, please indicate new name above in Section 1.

If changing ownership, both parties must sign the back of the form.

Change My Name From _____ To _____

Change Ownership From _____ To _____

2 CHANGE COVERAGE PLAN TYPE (YOU MUST COMPLETE SECTION 4, MEDICAL QUESTIONNAIRE, FOR BENEFIT CHANGES):

CHANGE PLAN TYPE	
FROM: <input type="checkbox"/> Individual (Ind.) <input type="checkbox"/> Ind. & Spouse <input type="checkbox"/> Ind. & Child(ren) <input type="checkbox"/> Ind./Spouse/Child(ren)	TO: <input type="checkbox"/> Individual (Ind.) <input type="checkbox"/> Ind. & Spouse <input type="checkbox"/> Ind. & Child(ren) <input type="checkbox"/> Ind./Spouse/Child(ren)
REASON(S) FOR CHANGE <input type="checkbox"/> Birth – date _____ <input type="checkbox"/> Divorce – date _____ <input type="checkbox"/> Death – date _____ <input type="checkbox"/> Marriage – date _____ Maiden Name (if applicable) _____ <input type="checkbox"/> Request for Reinstatement <input type="checkbox"/> Remove Extra Premium Placed On: _____ <input type="checkbox"/> Remove Exclusion Rider Placed On: _____ <input type="checkbox"/> Remove Tobacco User Rate – Length of Time Tobacco-Free: _____ <input type="checkbox"/> Other: _____	

BENEFIT CHANGES TO DEDUCTIBLE (Notice: You cannot change product type.)	
For BlueSolution PPO Members Only	
FROM:	<input type="radio"/> \$750 <input type="radio"/> \$1,500 <input type="radio"/> \$3,000 <input type="radio"/> \$5,000
TO:	<input type="radio"/> \$750 <input type="radio"/> \$1,500 <input type="radio"/> \$3,000 <input type="radio"/> \$5,000
For HSA Blue PPO and HSA Blue PPO Plus Members Only (Deductible Changes Must Be Made Effective in January for this product):	
FROM:	<input type="radio"/> \$1,000 <input type="radio"/> \$2,000 <input type="radio"/> \$2,650 <input type="radio"/> \$5,100 <input type="radio"/> \$5,250 <input type="radio"/> \$10,200
TO:	<input type="radio"/> \$1,000 <input type="radio"/> \$2,000 <input type="radio"/> \$2,650 <input type="radio"/> \$5,100 <input type="radio"/> \$5,250 <input type="radio"/> \$10,200
BENEFIT CHANGES TO OPTIONS	
<input type="checkbox"/> ADD MATERNITY COVERAGE (Application to add maternity coverage can only be made within 30 days of marriage and prior to date of conception. Maternity coverage is medically underwritten and available only to individuals 18 years of age and older.)	
<input type="checkbox"/> DELETE MATERNITY COVERAGE (Maternity coverage may be deleted at any time. However, it <u>cannot</u> be reinstated without medical underwriting and is subject to eligibility criteria.)	
<input type="checkbox"/> DELETE TERM LIFE INSURANCE (Once term life insurance is deleted, it cannot be reinstated.)	

3 CHANGE IN DEPENDENT STATUS (Complete Medical Questionnaire if adding dependents) ■ ADD ■ DELETE

LAST NAME	FIRST NAME	M.I.	SEX	D.O.B.	S.S.N.	RELATIONSHIP	HEIGHT	WEIGHT

A. Do all proposed applicants reside in same household? YES NO
If no, provide details: _____

B. Do all proposed applicants live in Arkansas? YES NO
If no, provide details: _____

C. Will the coverage applied for replace or change any existing hospital, medical or major medical insurance if the coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant? YES NO
If yes, name of company _____, I.D. No. _____ Date of Termination ____/____/____
Address _____

D. Are you or any dependents to be covered by this policy also covered by Medicare? YES NO
If yes, effective date ____/____/____. Persons to be covered by Medicare: _____

FOR HOME OFFICE USE ONLY (DO NOT WRITE IN THIS SPACE)

I.D. NO.	GROUP NO.	EFFECTIVE DATE
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4 MEDICAL QUESTIONNAIRE

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

For each question answered "YES," circle the condition requiring treatment and give full details in the ADDITIONAL MEDICAL INFORMATION box below.

1. Has any person to be insured ever been declined, rated, restricted or modified for the issuance of life, accident or health insurance? 1. Yes No

2. Has any person to be insured ever had or been told he/she had:
 - a. asthma, allergies, bronchitis, emphysema, obstructive or reactive airway disorder, pleurisy, sleep apnea, or any disorder of lungs, bronchial tubes, or respiratory system? 2. (a) Yes No
 - b. epilepsy, convulsions, seizures, vertigo or fainting, paralysis, parkinsonism, neuritis, migraine headaches, or any disorder of the brain or nervous system? (b) Yes No
 - c. mental disease, nervous disorder, emotional problems, anxiety, depression, eating disorder, psychiatric treatment, counseling, drug overdose, or attempted suicide? (c) Yes No
 - d. high blood pressure, arteriosclerosis, heart attack, stroke, heart murmur, palpitation of the heart, chest pain or shortness of breath, or any disorder of the heart, blood, blood vessels or circulatory system? (d) Yes No
 - e. back pain, arthritis, arthralgia, fibromyalgia, chronic fatigue, rheumatic fever, gout or any disorder of the muscles, bones or joints? (e) Yes No
 - f. cataracts, glaucoma, nasal septal defect, sinusitis, tonsillitis, or any disorder of the eyes, ears, nose, throat or esophagus? (f) Yes No
 - g. gastric or duodenal ulcer, indigestion, colitis or irritable bowel syndrome, gastric bypass, gastric reflux, hernia, hepatitis, or disorder of the stomach, intestines, liver, gall bladder or rectum? (g) Yes No
 - h. diabetes, goiter or any other disorder of the thyroid, pituitary, adrenal, pancreas or other glands? (h) Yes No
 - i. renal stones, bladder stones, nephritis, albumin, sugar or blood in the urine, or any disorder of the kidneys or urinary tract, or male or female reproductive organs including prostate, ovaries or breasts? (i) Yes No
 - j. cancer, melanoma, leukemia, anemia, tumor, neoplasm, malignancy of any kind or disorder of the lymphatic system or skin? (j) Yes No
 - k. any existing injury, deformity, incapacitation, disease or condition not listed elsewhere? (k) Yes No

3. Has any person to be insured, or a dependent of the proposed insured (**whether applying for coverage or not**), ever been treated for infertility? (If yes, a separate application must be completed on each person applying for coverage.) 3. Yes No

4. Has any person to be insured ever had a c-section? 4. Yes No

5. During the past 5 years has any proposed insured:
 - a. consulted, been examined, or treated by any physician or practitioner? 5. (a) Yes No
 - b. had x-rays, EKG, or any laboratory test or study? (b) Yes No
 - c. had or been advised to have a surgical operation? (c) Yes No
 - d. been confined or treated at any hospital, clinic, sanitarium, or other medical facility? (d) Yes No

*Physician name and address **must** be provided below for any proposed applicant who is 12 months of age or younger.

ADDITIONAL MEDICAL INFORMATION – List below full details to questions answered "YES." (Use separate sheet if necessary; sign, date, and attach to the application.)

Question Number	Person Treated	Condition and Type of Treatment	Date Occurred	Date Recovered	Degree of Recovery			Complete Name and Address of Physician
					None	Partial	Full	

Is any person to be covered, or a dependent (whether applying for coverage or not) of an applicant, now pregnant or an expectant parent? (If yes, a separate application must be completed on each person applying for coverage.) Yes No

Name _____ Expected Delivery Date _____

4 MEDICAL QUESTIONNAIRE (continued)

PRESCRIPTION INFORMATION

List below full details to questions answered "YES." (Use separate sheet if necessary; sign, date, and attach to the application.)

6. Is any proposed insured currently taking any prescription medication, or taken prescription medication in the last 3 years? 6. Yes No

If "YES," provide details in the PRESCRIPTION INFORMATION box below.

Person Treated	Name of Drug	Dosage	Condition or Illness	Start Date	Stop Date	Degree of Recovery			Complete Name and Address of Physician
						None	Partial	Full	

THERAPY OR TREATMENT INFORMATION

List below full details to questions answered "YES." (Use separate sheet if necessary; sign, date and attach to the application.)

7. Has any proposed insured received occupational therapy, physical therapy, speech therapy, or chiropractic treatments? 7. Yes No
8. Has any person to be insured ever:
- a. consumed alcohol to excess, received treatment, or joined an organization for alcoholism or drug addictions? 8. (a) Yes No
- b. used any addictive or non-addictive drug or substance except as provided by a physician? (b) Yes No
- c. been treated for or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), or AIDS-related complex or Immune Deficiency Disorder? (c) Yes No

Person Treated	Number of Treatments	Condition and Type of Treatment	Date of First Visit	Date of Last Visit	Degree of Recovery			Complete Name and Address of Physician
					None	Partial	Full	

9. Have questions 1 through 8 been answered with respect to all persons to be covered? If no, explain _____ 9. Yes No

5 TOBACCO USAGE

Have you or any of the persons 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: Yes No

Name _____ Type _____ Amount _____

Name _____ Type _____ Amount _____

Name _____ Type _____ Amount _____

6 OTHER

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

If yes, give details: _____

List below the name, driver's license number and state of issue for all licensed applicants:

Applicant _____ Dependent _____

Spouse _____ Dependent _____

Has any person to be covered had their driver's license suspended or revoked, or had two or more moving traffic violations in the past two years? Yes No

Does any person to be covered intend to pilot a private aircraft or participate in sky or scuba diving; ballooning; motor vehicle, boat or snowmobile racing; mountain climbing; hang gliding; or any other hazardous sport, hobby or activity?

Yes No If yes, please explain: _____

7 PLEASE READ BEFORE SIGNING

I understand that the benefits for which I (we) will be eligible are those described in the Arkansas Blue Cross and Blue Shield insurance policy. I understand that coverage will not become effective before the approved effective date. I understand that in addition to other exclusions and limitations provided in the Arkansas Blue Cross and Blue Shield policies, no benefits WILL BE AVAILABLE FOR 12 MONTHS FOR THE TREATMENT OF ANY CONDITION WHICH EXISTED BEFORE THE EFFECTIVE DATE OF MY COVERAGE. NO BENEFITS WILL BE AVAILABLE FOR ANY CONDITION(S) SPECIFICALLY EXCLUDED BY AMENDMENT OR ENDORSEMENT.

In signing this application, I represent that the statements and answers given in this application are true, complete and correctly recorded. I understand that Arkansas Blue Cross and Blue Shield may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if incorrect information has been given on this application. If fraudulent misstatements were made, Arkansas Blue Cross and Blue Shield may take legal action at any time.

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 LOCATION (This application must be signed in the state of Arkansas.)

This application was signed in _____, Arkansas.
City

SIGNATURE SECTION (Please sign appropriate line only)

Proposed Insured's Signature OR Parent's/Legal Guardian's Signature (if policy for a minor)	X	Date Signed	
Spouse's Signature (if applying)	X	Date Signed	
Dependent(s) Over Age 18 Signature	X	Date Signed	

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)			
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 S.S. #	SALES REPRESENTATIVE'S SIGNATURE X	DATE SIGNED
AGENCY FEDERAL TAX ID # (if applicable)	SALES REPRESENTATIVE'S NAME (Please print) X	DATE SIGNED

COMMENTS:

FOR HOME OFFICE USE ONLY

HOME OFFICE ENDORSEMENTS:

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