

**BasicBlue**  
**Change Request Form**  
**for Current Policy**



**IMPORTANT — COMPLETE ALL SECTIONS IN BLACK INK (PLEASE PRINT) AND SIGN ON BACK**

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

**CHANGE COVERAGE AS INDICATED BELOW**

**1 CHANGE IN NAME OR COVERAGE OWNERSHIP**

**IMPORTANT:** If changing name, please indicate new name above.

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**

**PLAN TYPE:**

- Individual  Individual  
 Individual and Children  
 Individual and Spouse  Family

**OPTIONS:**

- |  |  |
|--|--|
| <b>ADD:</b>  | <b>DELETE:</b>   |
| <input type="checkbox"/> Physician Office Visits Rider | <input type="checkbox"/> Physician Office Visits Rider |
| <input type="checkbox"/> Prescription Drugs Rider      | <input type="checkbox"/> Prescription Drugs Rider      |
|  | <input type="checkbox"/> Tobacco User Rate             |
|  | <input type="checkbox"/> Extra Premium Charged         |
|  | <input type="checkbox"/> Exclusion Rider               |

**REASON(S) FOR CHANGE:**

- Death — date \_\_\_\_\_  
 Divorce — date \_\_\_\_\_  
 Birth — date \_\_\_\_\_  
 Marriage — date \_\_\_\_\_  
 Maiden Name (if applicable) \_\_\_\_\_  
 Request for Reinstatement  
 Other — Explain \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**3 CHANGE IN DEPENDENT STATUS**

ADD  DELETE

DO ALL PROPOSED APPLICANTS RESIDE IN THE SAME HOUSEHOLD?  YES  NO

IF NO, PROVIDE DETAILS: \_\_\_\_\_

LAST NAME	FIRST NAME	M.I.	SEX	DATE OF BIRTH	S.S. NO.	RELATIONSHIP	HEIGHT	WEIGHT

A. 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

If yes, name of company \_\_\_\_\_, I.D. No. \_\_\_\_\_ Date of Termination \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_

B. Are you or any dependent to be covered by this policy also covered by Medicare?  Yes  No

If yes, effective date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Persons covered by Medicare: (1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_

**4 MEDICAL QUESTIONNAIRE**

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

**I. Have you or any other persons to be insured**

A. Ever been declined, rated, restricted or modified for the issuance of life, accident or health insurance? (A)  Yes  No

B. Ever had or been diagnosed with or advised to have treatment or care for:

**[Circle condition(s) for which "yes" answer applies.]**

- |  |  |
|--|--|
| (1) High blood pressure or disease or disorder of the heart or circulatory system?   | (1) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (2) Allergies, asthma, sleep apnea, disease or disorder of the lungs or respiratory system?                                | (2) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (3) Disease or disorder of the kidneys, urinary tract, reproductive organs or breasts?                                     | (3) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (4) Disease or disorder of the liver, gallbladder, intestines, rectum, stomach or other vital organs, including hepatitis? | (4) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (5) Diabetes or high blood sugar? If yes, date of onset _____  | (5) <input type="checkbox"/> Yes <input type="checkbox"/> No |

(Continued On Next Page)

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

<input type="checkbox"/> Approved	<input type="checkbox"/> Denied	I.D. NO.	EFFECTIVE DATE	PLN.	PKG.	TOBACCO	NON-TOBACCO
<input type="checkbox"/> Approved with E.R. No. _____	<input type="checkbox"/> No Action _____						
<input type="checkbox"/> Approved without _____	Date _____						
<input type="checkbox"/> Approved with _____ %	Underwriter _____	GROUP NO.					
<input type="checkbox"/> Approved with Benefit Change	Date _____						

#### 4 MEDICAL QUESTIONNAIRE (Continued)

- (6) Seizures, nervous system disease or disorder including epilepsy, Parkinsonism, convulsions, or headaches? (6)  Yes  No
- (7) Mental disease, nervous disorder, emotional problems, anxiety, depression, any eating disorder, psychiatric treatment, counseling, drug overdose, or attempted suicide? (7)  Yes  No
- (8) Stroke, paralysis or physical incapacitation? (8)  Yes  No
- (9) AIDS/AIDS-related complex or immune deficiency disorder? (9)  Yes  No
- (10) Cancer or malignancy? (10)  Yes  No
- (11) Disease or disorder of blood, glands, skin or lymphatic system? (11)  Yes  No
- (12) Epstein-Barr or chronic fatigue syndrome? (12)  Yes  No
- (13) Back pain, arthritis, paralysis, disease or disorder of the muscles, bones or joints? (13)  Yes  No
- (14) Disease or disorder of eyes, ears, nose, throat or esophagus? (14)  Yes  No
- (15) Chronic pain, abnormal growths, chronic infections? (15)  Yes  No
- C. Ever had or been advised to have treatment or counseling for alcoholism or other drug dependency? (C)  Yes  No
- D. Consulted a physician or received hospital (inpatient or outpatient care) or rehabilitation services during the past five years? (D)  Yes  No
- E. Been in an automobile, boating, airplane, etc., accident within the last 5 years? (E)  Yes  No
- F. Received occupational therapy, physical therapy, speech therapy or chiropractic treatments? (F)  Yes  No
- G. Used sedatives, tranquilizers, cocaine or other hallucinogenic or narcotic drugs or received treatment for drug abuse or chemical dependency in the past 10 years? (G)  Yes  No
- H. Ever had or been advised to have treatment for any condition not listed? (H)  Yes  No
- II. In the past three years has any applicant had prescribed or taken any prescription drugs? If yes, please list medication and the prescribing physician and address below. II.  Yes  No
- III. Has any person to be insured, or a dependent of the proposed insured (whether applying for coverage or not), ever been treated for infertility? III.  Yes  No
- IV. Is any person currently covered, a person to be covered, or a dependent of an applicant (whether applying for coverage or not), now pregnant or an expectant parent? IV.  Yes  No
- Name \_\_\_\_\_ Expected Delivery Date \_\_\_\_\_
- V. Have you or any of the persons to be insured 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: V.  Yes  No
- Name(s) (1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_
- Type: \_\_\_\_\_ Type: \_\_\_\_\_ Type: \_\_\_\_\_
- VI. Is any applicant listed planning to travel or work outside the USA within the next two years? If yes, give details: VI.  Yes  No

List below full details to questions answered "yes". If separate sheet is needed, please date and sign.

Question No.	Person Treated	Condition – Type of Treatment Medication & Dosage	Date Occurred	Degree Recovery			Complete Name and Address of Physician
				None	Partial	Full	

#### 5 UNDERSTANDING, REPRESENTATIONS AND AGREEMENTS OF APPLICANT(S)

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.**

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 If yes, please explain: \_\_\_\_\_

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: \_\_\_\_\_

Note: This application must be signed in the state of Arkansas.

SIGNATURE OF APPLICANT	<b>X</b>	DATE SIGNED	
SIGNATURE OF SPOUSE	<b>X</b>	DATE SIGNED	
PARENT/GUARDIAN SIGNATURE (if policy for a minor)	<b>X</b>	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	DATE SIGNED
	<b>X</b>	
AGENCY FEDERAL TAX ID # (If applicable)	SALES REPRESENTATIVE'S NAME (Please print)	
	<b>X</b>	

COMMENTS:

#### FOR HOME OFFICE USE ONLY

HOME OFFICE ENDORSEMENTS

**THIS APPLICATION IS VALID ONLY WHEN COMPLETED AND SIGNED.**