



**Arkansas
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

BlueCare Dental Change Request Form

Return To: Arkansas Blue Cross, Attn: Change Request, P.O. Box 2181, Little Rock, AR 72203-2181

1 CURRENT POLICYHOLDER INFORMATION:

Member ID: _____ Group Number: _____ Date of Birth ___/___/___

First Name: _____ M.I.: _____ Last Name: _____

Phone Number: _____ Alternate 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 (must attach a completed Pre-Authorized Bank Draft Form and voided check)
 Quarterly Invoice Semi-Annual Invoice Annual Invoice

5 DELETE PERSON(S) FROM THE POLICY:

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

*Reason Codes: 1-Divorce 2-Student Status Change 3-Aging Off 4-Marriage 5-Death 6-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.

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

*Reason Codes: 1-Divorce 2-Student Status Change 3-Aging Off 4-Marriage 5-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 (must attach a completed Pre-Authorized Bank Draft Form and voided check)

Quarterly Invoice

Semi-Annual Invoice

Annual Invoice

8 PLEASE CHANGE MY PLAN TYPE:

Individual

Individual and Spouse

Individual and Child(ren)

Family

Please add the following dependent(s):

IMPORTANT NOTE: Children under age 19 and/or older must apply on their own.

Last Name	First Name	M.I.	Sex	Date of Birth	S.S. Number	Relationship

Do all dependents listed above live in the same household? Yes No

If no, provide reason: _____

Address: _____

Do all dependents listed above live in Arkansas? Yes No

Have any of the proposed insureds had Blue Care Dental within the last 12 months? Yes No

If yes, termination dates: ____/____/____

Member ID _____

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.

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.

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

Signature of CURRENT POLICYHOLDER (Parent/Guardian, if policy for a minor)	X	Date Signed	
Signature of NEW POLICYHOLDER	X	Date Signed	

For Home Office Endorsements:



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Monthly Bank Draft Program

HOW TO SIGN-UP FOR BANK DRAFT

IMPORTANT NOTE:

Depending on the product you are applying for and date your application is approved, we may or may not draft your first month's premium. Once the bank draft is in effect, you will receive no more statements.

1. Complete the information requested below.
2. Since we need information on your check, please attach a blank check from the account from which you want payment taken. Be sure to write "void" on the check before mailing it.
3. Complete the authorization form below and return to Arkansas Blue Cross and Blue Shield, P.O. Box 2181, Little Rock, AR 72203-2181
4. If payment is to be withdrawn from an account other than yours, the person making your payments should follow the above directions.

After we receive your Authorization Form and voided check, we will change your payment method to the Bank Draft Program. You will be notified by letter of the effective date of your first draft. Please allow approximately 30 days to establish the pre-authorized draft. If you receive a bill during this time, pay it as you normally would.

INSURED(S) INFORMATION

Name _____

Address _____

Street Apt. No

City State Zip

BANK ACCOUNT INFORMATION

Bank Name _____ Name on Account _____
(if different than the insured)

Routing Number _____ Account Number _____

Type of Account: Checking Savings

IMPORTANT: PLEASE READ BEFORE SIGNING

I authorize Arkansas Blue Cross and Blue Shield, a Mutual Insurance Company, and/or USABLE Life, and the BANK* indicated above, to debit my Arkansas Blue Cross and/or USABLE Life premium from my checking or savings account indicated above. 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 will also be terminating my Arkansas Blue Cross and/or USABLE Life coverage, UNLESS Arkansas Blue Cross and/or USABLE Life 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.

Signature _____ Date _____

Signature of Bank Account Holder

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

I.D. NO.	EFFECTIVE DATE