



CHANGE REQUEST FORM FOR CURRENT POLICY

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

1 CURRENT POLICY INFORMATION (PLEASE USE LEGAL NAME)

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NO.
CURRENT ID #	CURRENT GROUP #	BIRTH DATE	SEX

2 CHANGE NAME OR COVERAGE OWNERSHIP

Important: If changing ownership, both parties must sign the back of this form. Please indicate reason for change in Section 6A.

Change My Name From _____ To _____

Change Ownership From _____ To _____

3 CHANGE ADDRESS

BILLING ADDRESS (only for billing)			MAILING ADDRESS* (if different from billing address)		
STREET			STREET		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE

***IMPORTANT: Confidential medical information may be mailed to the mailing address.**

4 CHANGE TELEPHONE INFORMATION

HOME PHONE NO. ()	BUSINESS PHONE NO. ()	E-MAIL ADDRESS
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5 CHANGE BILLING MODE

Monthly Bank Draft (attach Bank Draft Form) Quarterly Semi-Annually Annually

List Bill Additions (**for agent use only**) List Bill # _____

6A CHANGE COVERAGE

(YOU MUST COMPLETE SECTION 15, MEDICAL QUESTIONNAIRE, FOR BENEFIT CHANGES EXCEPT WHEN ADDING A NEWBORN TO A FAMILY POLICY. A FAMILY POLICY CONSISTS OF TWO OR MORE PEOPLE ON THE POLICY PRIOR TO ADDING THE NEWBORN.)

CHANGE PLAN TYPE **FROM:** Individual (Ind.) Ind. & Spouse Ind. & Child(ren) Ind./Spouse/Child(ren)

TO: Individual (Ind.) Ind. & Spouse Ind. & Child(ren) Ind./Spouse/Child(ren)

REASON(S) FOR CHANGE

<input type="checkbox"/> Birth - Date _____	<input type="checkbox"/> Request for Reinstatement _____
<input type="checkbox"/> Adoption - Date _____ (Temporary or final adoption papers must accompany Change Request Form.)	<input type="checkbox"/> Remove Extra Premium Placed On: _____
<input type="checkbox"/> Divorce - Date _____	<input type="checkbox"/> Remove Exclusion Rider Placed On: _____
<input type="checkbox"/> Death - Date _____	<input type="checkbox"/> Remove Tobacco User Rate – Length of Time Tobacco-Free: _____
<input type="checkbox"/> Marriage - Date _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Maiden Name (if applicable) _____	

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

I.D. NO.	GROUP NO.	EFFECTIVE DATE
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6B MY CURRENT BENEFITS

STEP 1:

Choose your current deductible

\$500

\$1,000

\$2,500

\$5,000

\$10,000

\$25,000

After you meet the deductible, then you begin paying the 20% coinsurance, if applicable.

STEP 2:

Choose your current coinsurance or copayments

20% coinsurance up to a \$1,000 out-of-pocket coinsurance maximum

20% coinsurance up to a \$1,000 out-of-pocket coinsurance maximum

No coinsurance

\$30 Primary Care Physician visits copay/\$50 Specialist visits copay

\$30 Primary Care Physician visits copay/\$50 Specialist visits copay

\$30 Primary Care Physician visits copay/\$50 Specialist visits copay

In this section, you must check one box.

OR

20% coinsurance up to a \$2,000 out-of-pocket coinsurance maximum

20% coinsurance up to a \$2,000 out-of-pocket coinsurance maximum

20% coinsurance up to a \$2,000 out-of-pocket coinsurance maximum

Physician services subject to deductible

Physician services subject to deductible

Physician services subject to deductible

— YOUR SELECTED DEDUCTIBLE OPTION ALSO INCLUDES —

\$30 Primary Care Physician visits copay/\$50 Specialist visits copay

\$30 Primary Care Physician visits copay/\$50 Specialist visits copay

\$30 Primary Care Physician visits copay/\$50 Specialist visits copay

No coinsurance

No coinsurance

No coinsurance

6C CHANGE MY BENEFITS TO:

STEP 1:

Choose your requested deductible

If any person on the policy has satisfied his or her annual deductible, deductible change cannot be requested until November for a January 1 effective date.

\$500

\$1,000

\$2,500

\$5,000

\$10,000

\$25,000

After you meet the deductible, then you begin paying the 20% coinsurance, if applicable.

STEP 2:

Choose your requested coinsurance or copayments

20% coinsurance up to a \$1,000 out-of-pocket coinsurance maximum

20% coinsurance up to a \$1,000 out-of-pocket coinsurance maximum

No coinsurance

\$30 Primary Care Physician visits copay/\$50 Specialist visits copay

\$30 Primary Care Physician visits copay/\$50 Specialist visits copay

\$30 Primary Care Physician visits copay/\$50 Specialist visits copay

In this section, you must check one box.

OR

20% coinsurance up to a \$2,000 out-of-pocket coinsurance maximum

20% coinsurance up to a \$2,000 out-of-pocket coinsurance maximum

20% coinsurance up to a \$2,000 out-of-pocket coinsurance maximum

Physician services subject to deductible

Physician services subject to deductible

Physician services subject to deductible

— YOUR SELECTED DEDUCTIBLE OPTION ALSO INCLUDES —

\$30 Primary Care Physician visits copay/\$50 Specialist visits copay

\$30 Primary Care Physician visits copay/\$50 Specialist visits copay

\$30 Primary Care Physician visits copay/\$50 Specialist visits copay

No coinsurance

No coinsurance

No coinsurance

6D CHANGE PRESCRIPTION DRUG PLAN

FROM: Complete Care Essential Care

TO: Complete Care Essential Care

6E OPTIONAL BENEFIT CHANGES

ADD MATERNITY COVERAGE – Application to add maternity coverage must be made prior to date of conception. Maternity coverage is medically underwritten and only available to policyholders or their spouses, 18 years of age or older.

DELETE MATERNITY COVERAGE – Maternity coverage may be deleted at any time. However, it cannot be reinstated without medical underwriting and is subject to eligibility criteria.

DELETE TERM LIFE INSURANCE – Once term life insurance has been deleted, it cannot be reinstated.

7 CHANGE IN DEPENDENT STATUS

■ ADD ■ DELETE

LAST NAME	FIRST NAME	M.I.	SEX	BIRTH DATE	SOCIAL SECURITY NO.	RELATIONSHIP	HEIGHT	WEIGHT

8 STUDENT INFORMATION [Dependent(s) Age 19 to 23] Must be full-time student(s).

DEPENDENT	SCHOOL ATTENDING	SEMESTER HRS.	EST. DATE OF GRADUATION
DEPENDENT	SCHOOL ATTENDING	SEMESTER HRS.	EST. DATE OF GRADUATION

9 HOUSEHOLD INFORMATION

- A. Do all proposed insureds reside in the same household? Yes No
 If no, provide reason: _____ Address: _____
- B. Do all proposed insureds reside in Arkansas? Yes No
 If no, provide reason: _____ Address: _____
- 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: _____

10 EMPLOYMENT INFORMATION (for new applicants applying for coverage)

NAME	EMPLOYER	JOB DUTIES
NAME	EMPLOYER	JOB DUTIES

11 DRIVER'S LICENSE INFORMATION (age 15 and older) (complete for new applicants only)

Name _____ Driver's License # _____ State Issued _____

Name _____ Driver's License # _____ State Issued _____

Name _____ Driver's License # _____ State Issued _____

Name _____ Driver's License # _____ State Issued _____

Has any person to be covered ever:

- a. had his/her driver's license suspended or revoked? (a) Yes No
- b. had two or more moving traffic violations in the past two years? (b) Yes No
- c. been convicted or charged with driving under the influence of alcohol or a controlled substance? (c) Yes No

If you answered "yes" to any of the above questions, you must provide the following information:

Name of person(s) and date of occurrence(s) _____

12 SPORTING OR HOBBY INFORMATION (age 15 and older)

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

Name of person _____ Please explain: _____

Name of person _____ Please explain: _____

(Attach extra sheet if necessary. Any attachment must be signed and dated.)

13 EXPECTANT PARENT INFORMATION

Is any **male** currently covered or applying for coverage an expectant parent? Yes No

Is any **female** currently covered or applying for coverage pregnant? Yes No

Name _____ Expected Delivery Date _____

14 TRAVEL OUTSIDE THE USA (new applicants only)

Is any person to be covered planning to travel or work outside the USA within the next two years? Yes No

If yes, country _____ Length of stay _____

Reason for travel _____

(Attach extra sheet if necessary. Any attachment must be signed and dated.)

15 MEDICAL QUESTIONNAIRE (to be completed for new applicants only)

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

1. Has any person to be insured ever had or been told he/she had:

(Each section must have at least one box checked.)

A. BRAIN OR NERVOUS SYSTEM DISORDERS

- Alzheimer's disease or senile dementia
- Amyotrophic lateral sclerosis (Lou Gehrig's Disease)
- Cerebral palsy
- Convulsions, epilepsy or seizures
- Meningitis
- Migraine headaches
- Multiple sclerosis, muscular dystrophy or myasthenia gravis
- Neuritis
- Paralysis
- Parkinson's disease
- Polyneuritis
- Vertigo, fainting or dizziness
- Any other disorder of the brain or nervous system
- None of the above apply to any applicants**

B. CIRCULATORY

- Angina, heart attack, myocardial infarction
- Arteriosclerosis, coronary artery disease, shunt placement and/or angioplasty
- Cerebrovascular accident (stroke), including transient ischemic attack (TIA)
- Chest pain, shortness of breath, heart murmur, palpitation of the heart
- Heart bypass surgery, pacemaker implant
- Heart surgery
- High blood pressure
- Hemophilia
- Any other disorder of the heart, blood, blood vessels or circulatory system
- None of the above apply to any applicants**

C. DIGESTIVE

- Cirrhosis
- Crohn's disease
- Gastric bypass surgery
- Gastric or duodenal ulcer
- Hepatitis
- Hernia
- Irritable bowel syndrome or gastric esophageal reflux disorder (GERD)
- Pancreatitis
- Pyloric stenosis
- Ulcerative colitis
- Any other disorder of stomach, intestines, liver, gall bladder or rectum
- None of the above apply to any applicants**

D. KIDNEY, URINARY, REPRODUCTIVE

- 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 applicants**

E. RESPIRATORY

- Allergies, asthma or bronchitis
- Chronic obstructive pulmonary disease
- Emphysema
- Lung disease
- Obstructive or reactive airway disorder
- Pleurisy
- Sleep apnea
- Any other disorder of the lungs, bronchial tubes or respiratory system
- None of the above apply to any applicants**

F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS

- Anemia
- Cancer
- Hodgkin's disease
- Leukemia
- Malignancy of any kind
- Melanoma, neoplasm or tumor
- Any other disorder of the lymphatic system
- Any other disorder of the skin
- None of the above apply to any applicants**

G. GLANDULAR DISORDERS

- Adrenal disorders
- Diabetes
- Goiter
- Pancreatitis
- Any other disorder of the pancreas
- Any other disorder of the thyroid, pituitary, adrenal or other glands
- None of the above apply to any applicants**

H. MUSCULOSKELETAL

- Arthralgia
- Arthritis
- Back pain
- Chronic fatigue
- Connective tissue disorder
- Fibromyalgia
- Gout
- Lupus, systemic
- Rheumatic fever
- Any other disorder of the muscles, bones or joints
- None of the above apply to any applicants**

I. EAR/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 applicants**

J. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE

- Anxiety, depression, emotional problems or nervous disorder
- Attempted suicide
- Counseling
- Drug overdose
- Eating disorder
- Psychiatric treatment
- Any other mental, emotional disorder or situation
- None of the above apply to any applicants**

K. OTHER

- Sarcoidosis
- Scarlet fever
- Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder
- Transplant recipient
- Hospitalization or nursing home confinement
- Any existing injury, deformity, incapacitation, disease or condition not listed elsewhere
- None of the above apply to any applicants**

For each question checked above, give full details in the ADDITIONAL MEDICAL INFORMATION, PRESCRIPTION INFORMATION and THERAPY OR TREATMENT INFORMATION sections which follow.

15 MEDICAL QUESTIONNAIRE (continued)

5. Is any proposed insured currently taking any prescription medication, or taken prescription medication in the last 3 years?

5. Yes No

ADDITIONAL PRESCRIPTION INFORMATION

If you answered Question 5 "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.

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

6. Has any proposed insured received occupational therapy, physical therapy, speech therapy, or chiropractic treatments?

6. Yes No

7. Has any person to be insured ever:

a. consumed alcohol to excess, received treatment, or joined an organization for alcoholism or drug addictions?

7. (a) Yes No

b. used any addictive or non-addictive drug or substance except as provided by a physician?

(b) Yes No

ADDITIONAL THERAPY OR TREATMENT INFORMATION

If you answered Questions 6 or 7 "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.

Person Treated	Number of Treatments	Specific 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	

16 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. The agent or broker involved in this insurance transaction may receive compensation from Arkansas Blue Cross and Blue Shield, or one of its affiliates, for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker. 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 Change Request Form, I represent that the statements and answers given in this Change Request Form are true, complete and correctly recorded. I understand that Arkansas Blue Cross and Blue Shield may, within three years of the date of this Change Request Form, void or terminate this coverage or deny claims for coverage if incorrect information has been given on this Change Request Form. If fraudulent misstatements were made, Arkansas Blue Cross and Blue Shield may take legal action at any time.

I certify that I signed this Change Request 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.

17 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 LICENSE #	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 CHANGE REQUEST FORM IS VALID FOR 90 DAYS ONLY WHEN COMPLETED AND SIGNED.

Important Information. Please read carefully.

Before completing this change request form, please read the following instructions:

- This change request form is a legal document. If approved, it will become a part of your contract. Therefore, it is very important that you provide **all** requested information and that it is accurate and legible.
- This change request form must be completed in dark blue or black ink. **No pencil, please.**
- Do **not** use liquid paper, correction fluid or “white out” to correct any mistakes you make on this application.
- If you make a mistake, please mark through the incorrect information, initial it and then provide the correct information.
- Any attached sheets must be signed and dated.
- Please ensure that all required parties sign and date the application.
- Please do **not** send money with this change request form.

Policy Effective Date

The effective date of this change will be the beginning of the next billing cycle, following approval. The change in coverage becomes effective upon the date of change to the policy and contingent upon receipt of premium.



Arkansas
BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

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