



**Arkansas  
BlueCross BlueShield**  
An Independent Licensee of the Blue Cross and Blue Shield Association

# Individual/Family Health Insurance Non-Underwriting Change Form

Before completing this Change Form  
please read the following instructions:

- This form is a legal document. It is very important that you provide all requested information and that it is accurate and legible.
- Please ensure that all required parties sign and date the form.
- This form must be completed in dark blue or black ink.
- 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.
- We strongly encourage you to make a photocopy of this completed form for your records.

## INSTRUCTION SHEET

**When you are completing this form, please refer to your Arkansas Blue Cross and Blue Shield identification card for your Member ID and Group #. This information must be entered correctly under Section 1 in order to process your request.**

**Effective Date:** Generally, any change requested on this form that affects your premium, will go into effect at the beginning of your next billing cycle. In the case of death, changes will be made the first of the month following the death or 15th of the month for those with a 15th of the month effective date.

**Billing Change:** Any request made to change your billing will be based on the current billing date of your policy.

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### Address Changes

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Any change to your current address information can be completed in **Section 2- Address Changes**. We have provided three separate listings for this information. Only complete for addresses that are changing.

**Residential** – This address will be noted as your physical place of residence.

**Mailing** – Correspondence such as letters and Explanations of Benefits (EOBs) will be mailed to this address.

**Billing** – All billing invoices will be generated to this address.

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### Name Change

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Documentation is **required** for any name change request. Please complete **Section 3 – Name Change** and attach appropriate documentation such as, a copy of your Marriage License, Divorce Decree, Adoption papers or other court papers to support the change.

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### Delete Person(s) From The Policy

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Life events may require you to make changes to your policy. Such events could include, but are not limited to:

Divorce

Student Status Change (no longer a full-time student)

Aging Off (child reaching dependent age limits)

Marriage (dependent child marries)

Death

In the event you would like to **terminate coverage** for a covered person, including the policyholder, you can do so by completing **Section 5-Delete Person From The Policy**.

**OR**

You have the option to **maintain the person's coverage** by splitting him/her off onto a new individual policy with identical coverage. This will completely remove him/her from your coverage and create a new policy for the covered person. You can make this change by completing **Section 7 – Split Policy**. A signature is **required** by **both** the current policyholder and new policyholder. **Important Note:** Complete one change form for each new policy you are requesting.

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### Benefit Changes

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If you need to change benefit information such as calendar-year deductibles, complete **Section 9 – Benefit Changes**. There is a separate section for each of our products. Please complete only the section for your product. If you are unsure of your product name, use the product group numbers listed as a reference. Your product group number can be found on your identification card under **Group #**. It will be the first six numbers before the dash.

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### Ownership Changes

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If both the policyholder and spouse are retaining coverage, but you would like to change the ownership of the policy from the current policyholder to the spouse, complete **Section 6 – Ownership Change**. Both the current policyholder and new policyholder must sign the change form.

**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 DELETE BENEFITS:**

- Term Life Insurance
- Maternity Rider

**9 BENEFIT CHANGES:**

**IMPORTANT NOTE:** Increasing the calendar-year deductible means that any claims processed by Arkansas Blue Cross after the effective date of change, regardless of the date of the service(s), will be applied to the new higher deductible.

**▲ ACCESS BLUE PPO (Group # 700101-700104 or 700201-700204)**

Increase My Calendar-Year Deductible To:       \$1,000       \$2,500

**▲ BASIC BLUE PPO (Group # 710000 or 720000)**

Delete My Benefit:       Physician Office Visits Rider       Prescription Drugs Rider

**▲ BLUECARE PPO (Group # 600010-600016 or 600020-600026)**

**BLUECARE PPO PLUS (Group # 600030-600036 or 600040-600046)**

Increase My Calendar-Year Deductible To:       \$1,000       \$1,500       \$2,500\*

Increase My Calendar-Year Coinsurance Maximum To:       \$10,000

\*\$2,500 has no coinsurance maximum

**IMPORTANT NOTE: Increasing the calendar-year deductible means that any claims processed by Arkansas Blue Cross after the effective date of change, regardless of the date of the service(s), will be applied to the new higher deductible.**

**▲ BLUECHOICE (Group # 771000-771023 or 781000-781020)**

**Increase my Calendar-Year Deductible and Benefit To:**

**\$500 Deductible Options**

- \$1,000 coinsurance maximum and EC Rx plan
- \$2,000 coinsurance maximum and CC Rx plan
- \$2,000 coinsurance maximum and EC Rx plan

**\$1,000 Deductible Options**

- \$1,000 coinsurance maximum and CC Rx plan
- \$1,000 coinsurance maximum and EC Rx plan
- \$2,000 coinsurance maximum and CC Rx plan
- \$2,000 coinsurance maximum and EC Rx plan

**\$2,500 Deductible Options**

- No coinsurance and CC Rx plan
- No coinsurance and EC Rx plan
- \$2,000 coinsurance maximum and CC Rx plan
- \$2,000 coinsurance maximum and EC Rx plan

**\$5,000 Deductible Options**

- \$30/\$50 copay and CC Rx plan
- \$30/\$50 copay and EC Rx plan
- No physician copays\* and CC Rx plan
- No physician copays\* and EC Rx plan

**\$10,000 Deductible Options**

- \$30/\$50 copay and CC Rx plan
- \$30/\$50 copay and EC Rx plan
- No physician copays\* and CC Rx plan
- No physician copays\* and EC Rx plan

**\$25,000 Deductible Options**

- \$30/\$50 copay and CC Rx plan
- \$30/\$50 copay and EC Rx plan
- No physician copays\* and CC Rx plan
- No physician copays\* and EC Rx plan

\*Physician visits subject to deductible.

**▲ BLUE SELECT (Group # 601000-601007 or 602000-602007)**

**Increase My Calendar-Year Deductible To:**       \$1,000       \$1,500       \$2,500

**Increase My Calendar-Year Coinsurance Maximum To:**       \$10,000

**Delete the following Benefit:**       SAE – Supplemental Accident Endorsement

**▲ BLUE SOLUTION (Group # 770000-770003 or 780000-780003)**

**Increase My Calendar-Year Deductible To:**       \$1,500       \$3,000       \$5,000

**▲ COMPREHENSIVE BLUE PPO (Group # 790000-790007 or 700000-700007)**

**Increase My Calendar-Year Deductible To:**       \$1,000       \$2,500       \$5,000       \$10,000  
     \$15,000       \$20,000       \$25,000

**▲ CONVERSION (Group # 902100-902140)**

**Increase My Calendar-Year Deductible and Benefit To:**

- \$ 500 Deductible, 80/20 Coinsurance, \$5,000 Calendar-Year Coinsurance Maximum
- \$1,000 Deductible, 80/20 Coinsurance, No Calendar-Year Coinsurance Maximum
- \$1,000 Deductible, 80/20 Coinsurance, \$5,000 Calendar-Year Coinsurance Maximum

**▲ HSA BLUE PPO (Group # 730000-730021 or 740000-740021)**

**HSA BLUE PPO PLUS (Group # 750000-750021 or 760000-760021)**

**Increase My Calendar-Year Deductible To:**

- \$3,000 Individual/\$5,950 Family Deductible, 100/0 Coinsurance, No Calendar-Year Coinsurance Maximum
- \$3,000 Individual/\$5,950 Family Deductible, 80/20 Coinsurance, \$10,000 Individual/\$20,000 Calendar-Year Coinsurance Maximum
- \$5,800 Individual/\$11,600 Family Deductible, 100/0 Coinsurance, No Calendar-Year Coinsurance Maximum





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# Pre-Authorized Bank Draft Monthly Program Sign Up Form

please...

thank you...

- ✓ Attach a VOIDED check from the account to be drafted
- ✓ Mail this authorization and the voided check to:

**ATTN: Cashiers (Drafts)**  
Arkansas Blue Cross Blue Shield  
P.O. Box 2181  
Little Rock, AR 72203

- ✓ For completing the information requested below
- ✓ For paying any statement that you receive by check or money order
- ✓ For noting the effective date of your first scheduled draft, sent by letter after receiving this completed authorization form

## Insured(s) Information

Name \_\_\_\_\_ I.D. Number \_\_\_\_\_

Address \_\_\_\_\_  
Street Apt. No.

\_\_\_\_\_ City State Zip

### Please check one of the following:

Currently, this insured's premium is **not** drafted

Currently, this insured's premium is drafted and the account information has changed

## 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