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

Individual/Family Health Insurance
UNDERWRITING CHANGE FORM

READ ALL INSTRUCTIONS BEFORE COMPLETING THIS CHANGE FORM. THE CHANGE FORM MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.

- This form is a legal document. If you are approved for coverage, it will become a part of your contract. Therefore, all information provided must be accurate and legible.
- This form must be completed in dark blue or black ink. Forms completed in **pencil** will not be accepted.
- If you make a mistake, mark through the incorrect information, initial it, date it, and provide the correct information.
- Do not use liquid paper, correction tape, or "white out" to correct any mistakes on this form.

INSTRUCTIONS

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

Effective Date: The effective date for any changes will be the next available effective date following approval, unless otherwise requested.

Arkansas
BlueCross BlueShield

UNDERWRITING CHANGE FORM
For Current Policy

Return To: Arkansas Blue Cross and Blue Shield
Attn: CRM Operations and Service
P.O. Box 2181
Little Rock, AR 72203-2181

OR

Fax to: 501-378-3752
E-mail: CRMCustomerService@arkbluecross.com

Changes to your policy can only be made during the annual open enrollment period (October 1-December 15), unless the change is a result of a qualifying life event such as birth of a child, adoption, loss of other coverage, marriage, etc.

SECTION 1 | CURRENT POLICYHOLDER INFORMATION

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.

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

First Name: _____ M.I.: _____ Last Name: _____ Social Security No.: _____

Residential Address: Street _____

City _____ State _____ Zip _____

SECTION 2 | CONTACT INFORMATION

Primary Phone Number	Alternate Phone Number	E-mail Address	How do you prefer we communicate with you?
( )	( )		❑ E-mail ❑ Phone

SECTION 3 | U.S. CITIZENSHIP STATUS

- For any applicant who is not a U.S. citizen, a copy of his/her Permanent Resident VISA or Green Card issued by the U.S. Citizenship and Immigrant Services may be required with the application.
- Applicants must reside in the U.S. at least one year and must have a primary care physician in the U.S. prior to being eligible to apply for coverage.
- Applicants who are not U.S. citizens may be contacted by phone to complete a Foreign National Questionnaire.

❑ Yes ❑ No Are all applicants U.S. citizens? If "no," please provide the name(s) of the applicant(s) who are not U.S. citizens.

Name: _____ Name: _____

CHANGES TO BE MADE

*Please review **all** sections and answer **all** applicable questions.*

SECTION 4 | POLICY CHANGE ELIGIBILITY

Check all applicable boxes below that support your eligibility and provide date of qualifying life event.

	Date		Date		Date
❑ 1–Annual Open Enrollment Period:	10/1 – 12/15	❑ 7–New Guardianship/Legal Custody/ Court Order to Add Child	_____	❑ 10–Military Leave	_____
❑ 2–Birth	_____			❑ 11–Military Reinstatement	_____
❑ 3–Adoption	_____	❑ 8–Loss of employer-sponsored health coverage*	_____	❑ 12–Eligible for other coverage*	_____
❑ 4–Death	_____			❑ 13–Other (Give specific details and date)	_____
❑ 5–Marriage	_____	❑ 9–Involuntary loss of other health coverage*	_____		
❑ 6–Divorce or Legal Separation	_____				

NOTE: If application is not received during the Open Enrollment Period, we must receive appropriate documentation with this application to confirm qualifying life event/special election period (i.e. copy of marriage license, Certificate of Creditable Coverage or attestation from previous insurance company, legal guardianship/custody documentation, etc.).

*If you are adding a spouse or dependent who is losing coverage of an existing insurance, please apply prior to the current policy end date to avoid a lapse in coverage. Please refer to Section 7 for more details.

SECTION 5 | POLICY APPEALS

❑ Request for Reinstatement: _____

❑ Remove Tobacco Surcharge: Name _____ Date Quit: _____/_____/_____

❑ Remove Other Surcharge: Name _____

❑ Remove Exclusion: Name _____ Excluded Condition _____

Name _____ Excluded Condition _____

SECTION 6 | ADD SPOUSE OR DEPENDENT(S)

Qualifying life event changes allow you to make changes to your policy outside of the annual open enrollment period. Such events include, but are not limited to:

❑ Obtaining guardianship, legal custody of a child, or court order requiring coverage for a dependent (requires proof of guardianship, legal custody or court order)
❑ Loss of Eligibility (requires a Certificate of Creditable Coverage referred to as COCC or attestation)
❑ Marriage (requires a copy of the marriage certificate)

First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Security No.	Height	Weight
								___ft.___in.	_____ lbs.
								___ft.___in.	_____ lbs.
								___ft.___in.	_____ lbs.
								___ft.___in.	_____ lbs.

SECTION 7 | CURRENT INSURANCE COVERAGE

❑ Yes ❑ No a. Will the coverage applied for replace or change current hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant?
i. If "yes," please provide name of carrier: _____
ii. If "yes," does the coverage have a specified termination date? If so, please provide date: _____/_____/_____
iii. If "yes," and the coverage does not have a specified termination date, will the coverage terminate if approved by Arkansas Blue Cross and accepted by the applicant?

❑ Yes ❑ No b. Have any applicants recently lost employer-sponsored health coverage?* If "yes," please provide:
Name: _____ Carrier Name: _____ Termination Date: _____/_____/_____
Name: _____ Carrier Name: _____ Termination Date: _____/_____/_____

❑ Yes ❑ No c. Have any applicants recently "involuntarily" lost other health coverage?* If "yes," please provide:
Name: _____ Carrier Name: _____ Termination Date: _____/_____/_____
Name: _____ Carrier Name: _____ Termination Date: _____/_____/_____

❑ Yes ❑ No d. Will any applicants be **continuing** any other health insurance? If "yes," please provide:
Name: _____ Carrier Name: _____ ID# _____
Name: _____ Carrier Name: _____ ID# _____

❑ Yes ❑ No e. Are any applicants covered by Medicaid (including AR Kids First)?
If "yes," please provide name(s) below:
Name: _____
Name: _____

❑ Yes ❑ No f. Are any applicants covered by or eligible for Medicare Part A or Part B or Medicare Advantage (Part C)? If "yes," please provide name(s) below:
Name: _____
Name: _____

*When your current policy ends, you may be given a Certificate of Creditable Coverage (COCC). A COCC is issued by your previous health insurance company and provides proof of prior coverage. Once you receive a COCC, please provide us a copy.

SECTION 8 | HOUSEHOLD INFORMATION

❑ Yes ❑ No a. Do all applicants under the age of 19 reside in the same household?
If "no," please provide reason and his/her name and address:
Name: _____ Address: _____
Reason: _____

❑ Yes ❑ No b. Are all applicants permanent, legal residents of Arkansas?
If "no," please provide reason and his/her name and address:
Name: _____ Address: _____
Reason: _____

SECTION 9 | APPLICANT(S) EMPLOYMENT INFORMATION [applicant(s) age 18 and older]

Name: _____ Employer: _____

Job Duties: _____

Name: _____ Employer: _____

Job Duties: _____

SECTION 10 | ADD MATERNITY

If your product is not listed, adding maternity is not an option.

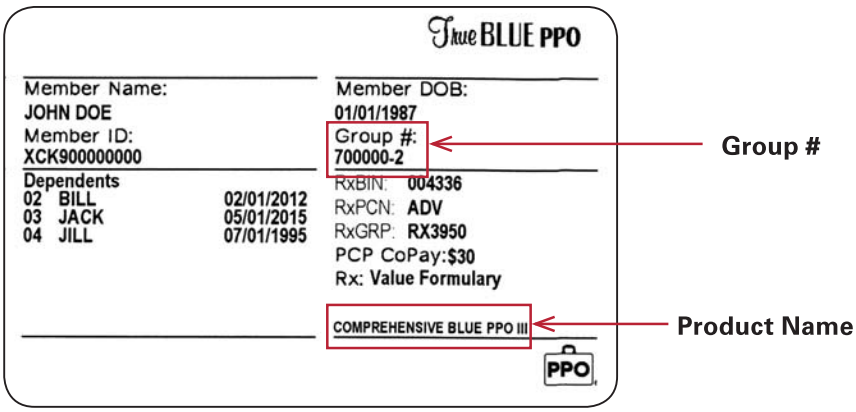
- ❑ BlueCare PPO*
- ❑ BlueCare PPO Plus*
- ❑ Blue Choice**
- ❑ Blue Select*
  - ❑ $2,000 ❑ $3,000 ❑ $5,000
- ❑ Blue Solution PPO*
- ❑ Comprehensive Blue PPO**
- ❑ Comprehensive Blue PPO II**
- ❑ HSA Blue PPO*
- ❑ HSA Blue PPO Plus*

*Must be prior to conception – cannot be pregnant prior to the effective date of maternity coverage.
**These plans have a 12-month waiting period before the maternity benefits will be covered.

SECTION 11 | BENEFIT CHANGES

- Section 11 reflects benefit options available for **all** individual policies. **Please complete only the section for your specific policy.**
- 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.
- **Note**: Only decreases to policy limits are allowed in the sections below. To increase policy limits, please fill out an new application.
- If you still have questions, call customer service at **1-800-238-8379.**

Sample Identification Card



▸ ACCESSBLUE PPO

Your Group # on your ID card will be one of these:
300101-300104 (non-grandfathered)
700101-700104 (grandfathered)

Decrease my calendar-year deductible to: ❑ $500 ❑ $1,000 ❑ $2,500

▸ BASIC BLUE PPO

Your Group # on your ID card will be one of these:
710000 (grandfathered)

Add benefit: ❑ Physician Office Visits Rider ❑ Prescription Drugs Rider

▸ BLUECARE PPO or BLUECARE PPO PLUS

Your Group # on your ID card will be one of these:
600010-600016 (grandfathered)
600030-600036 (grandfathered)

Decrease my calendar-year deductible to: ❑ $500 ❑ $1,000 ❑ $1,500

Decrease my calendar-year coinsurance maximum to: ❑ $1,000 ❑ $2,000

▶ BLUE CHOICE

Your Group # on your ID card will be one of these:
771000-771023 (grandfathered)

Decrease my calendar-year deductible and benefit to:

$500 Deductible Options
❑ $1,000 out-of-pocket coinsurance maximum
❑ $2,000 out-of-pocket coinsurance maximum

$1,000 Deductible Options
❑ $1,000 out-of-pocket coinsurance maximum
❑ $2,000 out-of-pocket coinsurance maximum

$2,500 Deductible Options
❑ No out-of-pocket coinsurance
❑ $2,000 out-of-pocket coinsurance maximum

$5,000 Deductible Options
❑ $30/$50 copay
❑ No physician copays*

$10,000 Deductible Options
❑ $30/$50 copay
❑ No physician copays*

$25,000 Deductible Options
❑ $30/$50 copay
❑ No physician copays*

*Physician visits subject to deductible.

▶ BLUE SELECT

Your Group # on your ID card will be one of these:
601000-601007 (grandfathered)

Decrease my calendar-year deductible to: ❑ $500 ❑ $1,000 ❑ $1,500

Decrease my calendar-year coinsurance maximum to: ❑ $1,000

▶ BLUE SOLUTION PPO

Your Group # on your ID card will be one of these:
780000-780003 (grandfathered)

Decrease my calendar-year deductible to: ❑ $750 ❑ $1,500 ❑ $3,000

▶ COMPREHENSIVE BLUE PPO or COMPREHENSIVE BLUE PPO II

Your Group # on your ID card will be one of these:
390000 – 390007 or 391000 – 398000 (non-grandfathered)
790000 – 790007 or 791000 – 798000 (grandfathered)

Decrease my calendar-year deductible to: ❑ $500 ❑ $1,000 ❑ $2,500 ❑ $5,000 ❑ $10,000 ❑ $15,000 ❑ $20,000

▶ COMPREHENSIVE BLUE PPO III

Your Group # on your ID card will be one of these:
790008-790016 (non-grandfathered)

Decrease my calendar-year deductible to: ❑ $1,000 ❑ $1,500 ❑ $2,500 ❑ $5,000 ❑ $7,500 ❑ $10,000 ❑ $15,000 ❑ $20,000

▶ HSA BLUE PPO or HSA BLUE PPO PLUS

Your Group # on your ID card will be one of these:
730000-730015 (grandfathered)
750000-750015 (grandfathered)

Decrease my calendar-year deductible to:
❑ $1,350 Individual/$2,700 Family Deductible, 80/20% Coinsurance, $10,000 Individual/$20,000 Family Coinsurance Maximum
❑ $3,500 Individual/$7,000 Family Deductible, 80/20% Coinsurance, $10,000 Individual/$20,000 Family Coinsurance Maximum
❑ $3,500 Individual/$7,000 Family Deductible, 0% Coinsurance, No Calendar-Year Coinsurance Maximum

SECTION 11 | BENEFIT CHANGES (continued)

- **HSA BLUE PPO II**
  Your Group # on your ID card will be one of these:
  311000-311005 (non-grandfathered)
  711000-711005 (grandfathered)

  Decrease my calendar-year deductible to: ❑ $1,500 Individual/$3,000 Family Deductible
  ❑ $2,500 Individual/$5,000 Family Deductible

SECTION 12 | DRIVER'S LICENSE INFORMATION [applicant(s) age 14 and older]

Name: _____ License No. : _____ State: _____

Name: _____ License No. : _____ State: _____

Name: _____ License No. : _____ State: _____

In the past 5 years, has any applicant:

❑ Yes ❑ No a. Had his or her driver's license suspended or revoked?

❑ Yes ❑ No b. Had two or more moving traffic violations?

❑ Yes ❑ No c. Been convicted or charged with driving under the influence of alcohol or a controlled substance?

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

Name: _____ Date: _____/_____/_____ Violation(s): _____

Name: _____ Date: _____/_____/_____ Violation(s): _____

SECTION 13 | SPORTING OR HOBBY INFORMATION

❑ Yes ❑ No Does any applicant intend to pilot a private aircraft; race a motor vehicle, boat or snowmobile; or participate in sky or scuba diving, ballooning, mountain climbing, hang gliding or any other hazardous sport, hobby or activity?

Name: _____ Please explain: _____

Name: _____ Please explain: _____

SECTION 14 | TRAVEL OUTSIDE THE USA

❑ Yes ❑ No Is any applicant planning to travel or work outside the USA within the next two years?
If "yes," please provide the following:

Name (list all that apply): _____

Country: _____ Expected Length of Stay: _____ Departure date: _____ Return date: _____

Reason for Travel: _____

_____

_____

_____

_____

SECTION 15 | EXPECTANT/ADOPTIVE PARENT INFORMATION

❑ Yes ❑ No Is any **male** applying for coverage an expectant father or a potential adoptive father?

❑ Yes ❑ No Is any **female** applying for coverage pregnant or a potential adoptive mother?

If "yes," please provide the following: Name: _____ Expected Delivery/Adoption Date: ____/____/_____

SECTION 16 | INFERTILITY

Has any applicant or spouse of an applicant **(whether applying for coverage or not)**:

❑ Yes ❑ No a. Ever been diagnosed or treated for infertility?

❑ Yes ❑ No b. Had surgical sterilization? If "yes," please provide the following:

Name: _____ Treatment/Procedure: _____ Date: ____/____/_____

Name: _____ Treatment/Procedure: _____ Date: ____/____/_____

SECTION 17 | TOBACCO USAGE

❑ Yes ❑ No Has any applicant to be covered used any form of tobacco within the last 12 months? If "yes," please provide the following:

Name: _____ Type/Amount: _____ Date Last Used: ____/____/_____

Name: _____ Type/Amount: _____ Date Last Used: ____/____/_____

Name: _____ Type/Amount: _____ Date Last Used: ____/____/_____

SECTION 18 | PREVIOUS INSURANCE EXPERIENCE

❑ Yes ❑ No Has any applicant ever been declined, rated, restricted or modified for the issuance of life, accident, health or long-term care insurance? If "yes," please provide the following:

Name: _____ Carrier Name: _____ Year: _____ Details: _____

Name: _____ Carrier Name: _____ Year: _____ Details: _____

SECTION 19 | PRESCRIPTION QUESTIONNAIRE

❑ Yes ❑ No Is any applicant **currently** taking any prescription medication, or has any applicant taken prescription medication in the **last 3 years?**

If you answered "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 printout from the pharmacy is not acceptable.

Please provide the name that would have been used at the time of the prescription (e.g., a maiden name may have been used).

Person Treated	Name of Drug	Dosage	Specific Disorder or Illness	Start Date/ Stop Date	Degree of Recovery			Complete Name and Address of Prescribing Physician
					None	Partial	Full	
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				

(Continued on page 7)

SECTION 20 | MEDICAL QUESTIONNAIRE

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

For each question checked below, give full details in the ADDITIONAL MEDICAL INFORMATION section which follows.

1. Has any applicant **ever** had or been told he/she had: **(Each section must have at least one box checked.** When multiple medical conditions are listed, please **CHECK all conditions that apply.)**

A. BRAIN OR NERVOUS SYSTEM DISORDERS
- ❑ Alzheimer's disease or senile dementia
- ❑ Amyotrophic lateral sclerosis (Lou Gehrig's disease)
- ❑ Cerebral palsy
- ❑ Concussion or brain injury
- ❑ Convulsions, epilepsy or seizures
- ❑ Headaches or migraines
- ❑ Meningitis
- ❑ Multiple sclerosis, muscular dystrophy or myasthenia gravis
- ❑ Neuritis
- ❑ Paralysis or palsy
- ❑ Parkinson's disease
- ❑ Polyneuritis
- ❑ Vertigo, fainting or dizziness
- ❑ Any other disorder of the brain or nervous system
- ❑ None of the above apply to any applicant(s)

B. CIRCULATORY
- ❑ Abnormal cholesterol/lipids
- ❑ Angina, heart attack, myocardial infarction
- ❑ Arteriosclerosis, atherosclerosis, coronary artery disease, stent placement or angioplasty
- ❑ Cerebrovascular accident (stroke), including transient ischemic attack (TIA)
- ❑ Chest pain, shortness of breath, heart murmur, palpitation of the heart, ablation and rheumatic fever
- ❑ Heart bypass surgery/pacemaker implant
- ❑ Heart or vein/artery surgery
- ❑ High blood pressure
- ❑ Hemophilia
- ❑ Valve repair/replacement
- ❑ Any other disorder of the heart, blood, blood vessels or circulatory system
- ❑ None of the above apply to any applicant(s)

C. DIGESTIVE
- ❑ Cirrhosis
- ❑ Crohn's disease or ulcerative colitis
- ❑ Gastric bypass surgery or other weight loss procedure
- ❑ Gastric or duodenal ulcer
- ❑ Hepatitis
- ❑ Hernia/hemorrhoids
- ❑ Irritable bowel syndrome or gastric esophageal reflux disorder (GERD
- ❑ Pancreatitis
- ❑ Pyloric stenosis
- ❑ Any other disorder of stomach, intestines, liver, gallbladder or rectum
- ❑ None of the above apply to any applicant(s)

D. KIDNEY, URINARY, REPRODUCTIVE
- ❑ Abnormal pap smear
- ❑ 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 applicant(s)

E. RESPIRATORY
- ❑ Allergies, asthma or bronchitis
- ❑ Chronic pulmonary disease, emphysema, lung disease or respiratory syncytial virus (RSV
- ❑ Obstructive or reactive airway disorder
- ❑ Sleep apnea, cpap, bipap or vpap
- ❑ Any other disorder of the lungs, bronchial tubes or respiratory system
- ❑ None of the above apply to any applicant(s)

F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS
- ❑ Anemia
- ❑ Cancer, leukemia or malignancy of any kind
- ❑ Hodgkin's or Non-Hodgkin's disease
- ❑ Melanoma, neoplasm or tumor
- ❑ Any other disorder of the lymphatic system
- ❑ Any disorder of the skin
- ❑ None of the above apply to any applicant(s)

G. GLANDULAR DISORDERS
- ❑ Adrenal disorders
- ❑ Diabetes, abnormal glucose
- ❑ Goiter or thyroid disease
- ❑ Any disorder of the pancreas
- ❑ None of the above apply to any applicant(s)

H. MUSCULOSKELETAL
- ❑ Arthritis, osteoarthritis, degenerative joint or disc disease
- ❑ Back pain and/or neck pain
- ❑ Chronic fatigue
- ❑ Connective tissue disorder
- ❑ Disease or disorder of the joints: knee s , shoulder(s), elbow(s), wrist(s), other
- ❑ Fibromyalgia, bursitis or tendonitis
- ❑ Fracture(s) or broken bone(s)
  Exposed bone ❑ Yes ❑ No
- ❑ Gout

(Continued on the next column)

MUSCULOSKELETAL (continued)
- ❑ Lupus, systemic
- ❑ Temporomandibular joint disorder (TMJ/TMD or craniomandibular disorder
- ❑ Any other disorder of the muscles, bones or joints to include chiropractic care
- ❑ None of the above apply to any applicant(s)

I. EARS/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 applicant(s)

J. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE
- ❑ Anxiety, insomnia, sleep disorder, depression, emotional problems or nervous disorder
- ❑ Attempted suicide
- ❑ Counseling or psychiatric treatment (in-patient or out-patient)
- ❑ Bipolar disorder, obsessive compulsive disorder or developmental disorder
- ❑ Eating disorder
- ❑ Any other mental, emotional disorder or situation, including ADD/ADHD
- ❑ None of the above apply to any applicant(s)

K. OTHER
- ❑ Current patient in a hospital or nursing home
- ❑ Pending Surgery Surgery Date: ___/___/____
- ❑ Sarcoidosis
- ❑ Breast implants
  ❑ Saline ❑ Silicone Surgery Date: __/__/__
- ❑ Any other implant(s), prosthetic device(s), internal fixation device s) or retained hardware (i.e.: pins, wires, screws, shunts, stents
- ❑ Acquired immune deficiency syndrome (AIDS , or AIDS-related complex or immune deficiency disorder or HIV
- ❑ Transplant recipient
- ❑ Any injury, deformity, incapacitation, disease or condition not listed elsewhere
- ❑ None of the above apply to any applicant(s)

(Continued on page 8)

SECTION 20 | MEDICAL QUESTIONNAIRE (continued)

2. Has any applicant ever:

❑ Yes ❑ No a. Consumed alcohol to excess, received treatment, or joined an organization for alcoholism or drug addictions?

❑ Yes ❑ No b. Used any addictive or non-addictive drug or substance for purposes other than recommended by your physician?

❑ Yes ❑ No c. Been treated for, diagnosed by or consulted a physician, psychotherapist, counselor or any other provider, or had any indication(s) of having a drug dependency/habit?

❑ Yes ❑ No d. Required the assistance of any other individual for performances of any activities of daily living? If "Yes," please explain: _____

❑ Yes ❑ No e. Been told that he/she has or has had hearing problems, ear disorder(s) or has need of hearing devices due to any kind of hearing or ear impairment, or does any applicant have an existing hearing aid device in place?

ADDITIONAL MEDICAL INFORMATION

Give full details to questions answered affirmatively (checked or answered "Yes") to explain answers to questions in SECTION 20. In addition to **condition/illness** please provide the **type of treatment** provided or planned – for example, surgery, X-rays, EKG, lab tests, hospitalization, emergency room visit, nursing home confinement, doctor visits, rehabilitation services, occupational therapy, physical therapy, speech therapy or chiropractic treatments. Please ensure you include **all** the treatments that apply. **Please use the name that would have been given at the time of the physician visit – e.g., a maiden name.**

Question Number(s)	Person Treated	Specific Disorder/Illness **and** Type of Treatment	Date of First Visit	Date of Last Visit	Total # of Visits	Degree of Recovery			Complete Name and Address of Physician
						None	Partial	Full	
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					

SECTION 21 | PHYSICIAN INFORMATION (Please provide for each applicant for the last five years)

Applicant's Name	Complete Name and Address of Physician	Date of Last Visit*	Reason for Visit	Treatment/ Results

*Please write **NO VISIT** in this box if the applicant has never seen the physician.

PLEASE READ BEFORE SIGNING

I understand: (1) This application may be rejected if the applicant is age 19 or older. (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 in this document, any coverage which may be issued to me shall be invalid if based on intentional misrepresentations of material fact or fraud. (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 (both front and back) 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.

I certify that I signed this change form in the state of Arkansas.

SIGNATURE SECTION | (Please sign appropriate line only)

Current Policyholder (required if policyholder is age 19 or older) **OR** Parent Legal/Guardian (if policy for a minor)	(Please Print) **X** (Please Sign) **X**	Date Signed
Spouse (required if applying)	(Please Sign) **X**	Date Signed
Dependent age 18 or older (required if applying)	(Please Sign) **X**	Date Signed

CUSTODIAL PARENT SECTION

If any applicant under age 19 (primary applicant or dependent), named on this application, does NOT reside with the policyholder indicated in Section 1, the **custodial parent's** signature is also required.

Custodial Parent's Name (please print)	**X**		Telephone No.	
Custodial Parent's Address	Street or PO Box	City	State	Zip
Custodial Parent's Signature	**X**		Date Signed	

IMPORTANT: Please be sure to also sign and return Page 10 of this document. We cannot process your application without the signed Authorization to Disclose Protected Health Information form.

THE FORM BELOW MUST BE COMPLETED IN ORDER TO PROCESS THE APPLICATION

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, pharmacy benefits manager, or other provider of healthcare services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any healthcare item or service in relation to the healthcare provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices. I understand that information re-disclosed may no longer be protected by federal privacy regulations. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, PO Box 2181, Little Rock, AR 72203-2181. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 et seq., the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 et seq. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 et seq. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

Applicants age 18 and older

This authorization must be signed by **each applicant age 18 or older.**

Print Name(s)	Signature	Date
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____

Applicants under age 18

List applicants under age 18 (Print Name).

_____

_____

_____

_____

_____ _____ ____/____/____

Parent/Legal Guardian's Signature (if policy for a minor) Date

Detach and keep for your records

FAIR CREDIT REPORTING ACT NOTICE – NOTICE TO PROPOSED INSURED

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to Arkansas Blue Cross and Blue Shield.

Your written request should be forwarded to: Arkansas Blue Cross and Blue Shield
Individual Underwriting Division ▪ P.O. Box 2181
Little Rock, Arkansas 72203-2181

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

IMPORTANT INFORMATION REGARDING GRANDFATHERED PLANS

Your Arkansas Blue Cross and Blue Shield coverage may be a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Arkansas Blue Cross and Blue Shield Customer Service at **1-800-238-8379.** You may also contact the U.S. Department of Health and Human Services at **www.healthcare.gov.**

RETURN INSTRUCTIONS

- Any **attachments** submitted with the change form must be signed and dated.
- Do not send any money with this change form.
- **Please ensure all required parties have signed and dated the change form prior to submission.**
- We strongly recommend you make a copy of this completed change form for your records.