Individual/Family dental | Change form

MUST BE SUBMITTED ELECTRONICALLY. PDF FOR RECORDING DATA ONLY.

Section 1 - Current policyholder information

Member ID number	Group number	Date of birth

First name	M.I.	Last name

Primary phone number	Alternate phone number	Email	Preferred contact method
			☐ Email ☐ Phone

Changes to be made

You may skip section(s) that do not apply to the change(s) you are making.
However, you must return all pages - even if blank.

Section 2 - Address change

Residential street	City	State	ZIP	County

Mailing street	City	State	ZIP

Billing street	City	State	ZIP

Section 3 - Name change

	First name	Middle initial	Last name
From:			
To:			

Is this name change as a result of marriage?
☐ Yes ☐ No Marriage date:

Is this name change as a result of divorce?
☐ Yes ☐ No Divorce date:

Other reason for change

Date of change:

Section 4 - Billing change

☐ **Monthly bank draft** (Must complete attached bank draft form) ☐ **Monthly direct billing** (Paper bill)

Section 5 - Delete person(s) from the policy

First name	M.I.	Last name	Suffix	Date of birth (mm/dd/yyyy)	Reason code* (see below)	Date of change

***Reason codes:** 1 - Divorce 2 - Aging off 3 - Marriage 4 - Death 5 - Other

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Section 6 - Ownership change

	First name	Middle initial	Last name
From:			
To:			

Section 7 - Split policy

Indicate the name of the covered person(s) you want covered on a separate policy with identical coverage.

First name	M.I.	Last name	Suffix	Date of birth (mm/dd/yyyy)	Reason code* (see below)	Date of change (mm/dd/yyyy)

Reason codes: 1 - Divorce 2 - Aging off 3 - Marriage 4 - Other (specify below)

Please provide address information for new policyholder ONLY:

Residential street	**City**	**State**	**ZIP**
Mailing street	**City**	**State**	**ZIP**
Billing street	**City**	**State**	**ZIP**

Please set up the billing mode for my new policy

☐ **Monthly bank draft** (Must complete attached bank draft form) ☐ **Monthly direct billing** (Paper bill)

Section 8 - U.S. citizenship status

Additional information may be required.

☐ 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

Section 9 - Adding spouse or dependent(s)

Please add the following dependent(s):

IMPORTANT NOTE: Children age 26 and older must apply on their own

First name	M.I.	Last name	Suffix	Relationship	Sex	Date of birth	Social Security no.

Waiting periods do not apply to children age 18 and under.

The **6-month waiting period** for Minor Restorative services (Silver, Gold or Platinum) and the **6-month waiting period** for Major Restorative services (Gold or Platinum) will be waived if you meet the following criteria:

1. Your application is received within **30 days** of the termination date of your previous coverage; and
2. No later than **60 days** from the effective date of your new policy with Arkansas Blue Cross and Blue Shield, you provide us with a copy of your previous dental policy Certificate of Coverage which reflects the policy's effective and termination dates.

You may include these documents with your change form. If you are submitting these documents after submission of your change form, fax them to Arkansas Blue Cross at 501-378-3752 or email them to CRMCustomerService@arkbluecross.com.

Section 9 - Adding spouse or dependent(s) *(Continued)*

☐ Yes ☐ No **Are all the added individual(s) permanent, legal residents of Arkansas? If "no," please provide:**

Name

Address

Reason

☐ Yes ☐ No **Have any of the proposed insureds had any other dental coverage within the last 12 months? If yes, list:**

Name	Effective date	Termination date

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.

☐ **I certify that I signed this application 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.

Signature section (please sign appropriate line only)

Current policyholder OR parent/legal guardian (if policy for a minor)

Please print	Please sign	Date signed

New policyholder

Please sign	Date signed

Custodial parent section

Custodial parent's name (please print)	**Telephone No.**

Custodial parent's address

Street or P.O. box	City	State	County	ZIP

Custodial parent's signature	**Date signed**

For home ofice use only (Do not write in this space)

Return instructions

Please return this signed form to:

Arkansas Blue Cross and Blue Shield
Attn: Change Request
PO Box 2181
Little Rock, AR 72203-2181

Fax: 501-378-3752
Email: CRMCustomerService@arkbluecross.com

Pre-authorized bank draft | Monthly program sign-up form

Our monthly bank draft service makes premium payments easy and convenient for you. Just a few steps now help assure your payments are made accurately and timely.

1. **Complete the information below.**
1. **Mail this completed authorization form to:**

   Arkansas Blue Cross and Blue Shield
   Attn: Cashiers (Drafts)
   P.O. Box 3590
   Little Rock, AR 72203

Important: Please read before signing

I authorize Arkansas Blue Cross and Blue Shield, USAble Life, and the BANK indicated below, to debit my Arkansas Blue Cross and/or USAble Life premium from my checking or savings account indicated below. 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 also will 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.

I understand that an insufficient check fee will be assessed for any payment returned to Arkansas Blue Cross as a result of insufficient funds.

Insured's information

First name	Last name			
Street address	**Apt. no.**	**City**	**State**	**ZIP**

Arkansas Blue Cross and Blue Shield member ID

Bank account information

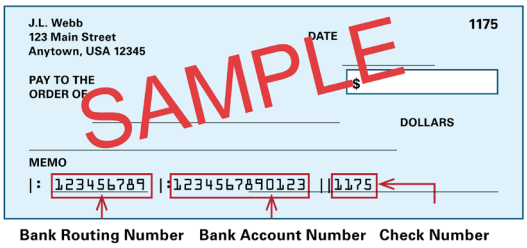
Bank name

Name on account (If different than the proposed insured)

Routing number	Account number

Type of account

☐ Checking ☐ Savings



Signature

Signature of bank account holder	Date

After Arkansas Blue Cross receives and processes this completed authorization form, you will receive a letter providing the effective date of your first scheduled draft. We hope you find this bank draft service of value. It is our privilege to serve you. Thank you for your business!

For office use only
(please do not write in this space)

ID No.
Effective date

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

USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products. USAble Life is solely responsible for the term life and critical illness policies referenced in your policy.