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

Application for COMPLETE

Type of coverage you're applying for:

■ **Complete Single Term**
A Complete Single Term is a short term, limited-term health insurance policy that provides health insurance coverage for a Term of less than 12 months after the Policy Effective Date; the Policy Term expires at 11:59 PM on the last day of the twelfth month. THIS POLICY IS NON- RENEWABLE.

■ **Complete Renewable Term**
A Complete Renewable Term is a short term, limited-term health insurance policy that provides health insurance coverage for a Term of less than 12 months after the Policy Effective Date; the Policy Term expires at 11:59 PM on the last day of the twelfth month. Upon expiration of the initial Term, the Policy may be renewed at the option of the policyholder for two subsequent terms, which will allow the Policy to have a duration of no longer than 36 months in total.

READ ALL INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION.
APPLICATION MUST BE COMPLETED IN ITS ENTIRETY IN ORDER TO BE PROCESSED.

This application 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 application must be completed in dark blue or black ink. Applications 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 application.
- Any **attachments** submitted with the application must be signed and dated.
- Please ensure all required parties have signed and dated the application prior to submission.
- **We strongly recommend you make a copy of this completed application for your records.**

SECTION 1 | WHO IS APPLYING

- Oldest person applying for coverage should be listed on the first line of the application. If applicant is under the age of 18, parent or guardian information should be indicated in Section 2 (Parent/Guardian).
- Social Security numbers are **required** for every applicant. If you are applying for coverage for a child less than one year old who does not yet have a Social Security number, you may apply; however, you will be required to submit the Social Security number within 90 days and children must be age six (6) months or older.
- If applying for Individual and Spouse coverage, primary applicant must be age 18 or older and spouse must be age 17 or older.
- If applying for Individual, Spouse and Child(ren) coverage or Individual and Child(ren) coverage, primary applicant must be age 18 or older and children must be six (6) months or older
- In "Relationship" box, indicate "spouse, son, daughter, stepson, stepdaughter, or dependent child" beside each dependent's name. -Eligible Complete dependents must be permanent residents of Arkansas and must be under the age of 26.
- If applying for coverage for dependent child other than son, daughter, stepson, or stepdaughter, submit copy of appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.
- If primary applicant is under age 18 and does NOT reside with the Parent/Guardian named on this application, custodial parent must also sign the application (see Signature Section on Page 7).
- If any dependents are under age 18 and do NOT reside with the primary applicant, the custodial parent must also sign the application (see Signature Section on Page 7).

SECTION 2 | PARENT/GUARDIAN (If policy is only for a child under age 18)

- If applicant is under the age of 18, parent or guardian information must be indicated in this section.
- If applying for coverage as the "Guardian" of a dependent child under the age of 18, please submit appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.

SECTIONS 4, 5 AND 6 | ADDRESS INFORMATION

- You are required to provide address information when submitting this application. Please note there are three separate listings for this information. Complete all that apply.
  - **Residential** – This address will be noted as your physical place of residence.
  - **Mailing** – Correspondence such as letters and Explanations of Benefit (EOBs) will be mailed to this address.
  - **Billing** – All billing invoices will be mailed to this address.

SECTION 9 | 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 Immigration Services must be submitted 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 additional questions.

SECTION 10 | COMPLETE COVERAGE INFORMATION

- If applicant is applying for coverage other than "Individual," please indicate if still interested in coverage if one or more applicants is declined or ineligible. If "Yes" is selected, Arkansas Blue Cross will continue the underwriting process if one or more applicants is declined or ineligible. If "No" is selected, Arkansas Blue Cross will close out the application if one or more applicants is declined or ineligible.
- Single Term policies can increase deductibles and coinsurance but cannot decrease deductibles or coinsurance.
- Renewable Term policies can increase deductible and/or coinsurance at any time and can decrease deductibles or coinsurance after the policy has been effective 12 months.

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IMPORTANT NOTE: We cannot process your Complete application without this completed form.

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 benefit 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 affiliate or agents information concerning services, supplies, benefit 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 define 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).

This authorization includes authorization to release information on the diagnosis and treatment of mental illness, alcohol, and drug use, as well as authorization to release information on the diagnosis, treatment, and testing results related to HIV-AIDS, and sexually transmitted diseases, unless otherwise restricted by applicable law.

Please note the following consequences if you decline to sign this authorization for release of your medical information, or if you later revoke it: in that event, we may be unable to process your application or evaluate a claim for coverage and would then deny your application or your claim for policy benefits.

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

Applicants age 18 and 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

APPLICATION FOR COMPLETE

SECTION 1 | WHO IS APPLYING

Read all instructions for Section 1 before completing.

First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Security No.	Height	Weight
				Self				ft. in.	lbs.
								ft. in.	lbs.
								ft. in.	lbs.
								ft. in.	lbs.
								ft. in.	lbs.
								ft. in.	lbs.

SECTION 2 | PARENT/GUARDIAN (If policy is only for a child under age 18)

Additional information may be required. Read instructions for Section 2 before completing.

First Name	M.I.	Last Name	Relationship (Check One)
			☐ Mother ☐ Stepmother ☐ Guardian ☐ Father ☐ Stepfather

SECTION 3 | MARITAL STATUS

☐ Single (including widowed or divorced) ☐ Married (including separated)

SECTION 4 | RESIDENTIAL ADDRESS (Must be permanent address of the applicant(s) - No P.O. box, please)

Street	City	State	County	Zip
		AR		

SECTION 5 | MAILING ADDRESS (Complete only if different from residential address)

Street or P.O. Box	City	State	County	Zip

SECTION 6 | BILLING ADDRESS (Complete only if different from residential address)

Street or P.O. Box	City	State	County	Zip

SECTION 7 | CONTACT INFORMATION

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

Arkansas Blue Cross and Blue Shield may contact you, either directly or through a business associate, using your postal or email addresses, telephone numbers or other personal information, regarding your health insurance plan, healthcare providers participating in our networks, disease management, health education and health promotion, preventive care options, wellness programs, treatment or care coordination or case management activities of Arkansas Blue Cross and Blue Shield.

SECTION 8 | HOUSEHOLD INFORMATION

☐ Yes ☐ No a. Do all applicants under the age of 18 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 | 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

Type of Permanent Visa or Permanent Green Card

USCIS Category	Registration No.	Issue Date (Mo. Day Yr.)	Expiration Date (Mo. Day Yr.)

☐ Yes ☐ No Have all applicants applying for coverage resided in the U.S. for at least 12 continuous months? If "No", please provide the name(s) of the applicant(s) who have not resided in the U.S. for at least 12 continuous months.

Name

☐ Yes ☐ No Do all applicants applying for coverage have a Primary Care Physician established in the U.S.? If "No", please provide the name(s) of the applicant(s) who do not have a Primary Care Physician established in the U.S.

Name

OFFICE USE ONLY (do not write in this space)

I.D. No.	Group No.	Effective Date

(Continued on page 2)

APPLICATION FOR COMPLETE

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of pre-existing conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

SECTION 10 | COMPLETE COVERAGE INFORMATION

Duration:

☐ Single Term (up to 12 months) ☐ Renewable Term (up to 36 months)

Deductible:

☐ $1,000 Individual/$2,000 Family ☐ $2,500 Individual/$5,000 Family

☐ $5,000 Individual/$10,000 Family ☐ $7,500 Individual/$15,000 Family

Coinsurance:

☐ 20% ☐ 30%

☐ Yes ☐ No If you are applying for coverage other than "Individual," do you want to continue the application process if one or more applicants is declined or ineligible?

Requested Effective Date:

Arkansas Blue Cross and Blue Shield assigns 1st of the month effective dates. This is your opportunity to request an effective date that coordinates with the termination of current health insurance coverage. While we cannot guarantee a specific requested effective date, we will make every effort to accommodate the request. If your application is approved, the effective date will be assigned based on the date of approval. Retroactive effective dates will not be assigned.

Please write the day you would like your coverage to become effective:

Requested effective date: ____/01/_____

Monthly auto pay is required upon enrollment.

SECTION 11 | INSURANCE/OTHER INFORMATION

☐ Yes ☐ No a. Are any applicants covered by Medicaid (including AR Kids First)? If "Yes," please provide name(s) below:

Applicant Name:	
Applicant Name:	

☐ Yes ☐ No b. Are any applicants covered by Medicare? If "Yes," please provide name(s) below:

Applicant Name:	
Applicant Name:	

☐ Yes ☐ No c. Is any applicant Medicare disabled? If "Yes", please provide name(s) below:

Applicant Name:	
Applicant Name:	

☐ Yes ☐ No d. Do you or any applicant have current Arkansas Blue Cross Blue Shield coverage? If "Yes," please provide:

ABCBS ID#	

☐ Yes ☐ No e. Have you or any applicant had ABCBS coverage that has terminated within the last 6 months? If "Yes," please provide:

ABCBS ID#	

☐ Yes ☐ No f. Is any male applying for coverage an expectant father or a potential adoptive father? If "Yes", please provide:

Applicant Name:	

☐ Yes ☐ No g. Is any female applying for coverage pregnant or a potential adoptive mother? If "Yes", please provide:

Applicant Name:	

(Continued on page 3)

SECTION 11 | INSURANCE/OTHER INFORMATION (continued)

☐ Yes ☐ No h. Has any applicant ever consumed alcohol to excess, received treatment, or joined an organization for alcoholism or drug addictions? If "Yes", please provide name(s) below:

Applicant's Name	Complete Name and Address of Treatment Facility or Physician	Date Last Treated	Reason for Treatment

☐ Yes ☐ No i. Has any applicant ever used any addictive drug or substance for purposes other than recommended by your physician? If "Yes", please provide name(s) below:

Applicant's Name	Complete Name and Address of Treatment Facility or Physician	Date Last Treated	Reason for Treatment

☐ Yes ☐ No j. Do you have a valid Medical Marijuana Card?

☐ Yes ☐ No k. Has any applicant ever 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? If "Yes", please provide name(s) below:

Applicant's Name	Complete Name and Address of Treatment Facility or Physician	Date Last Treated	Reason for Treatment

☐ Yes ☐ No l. Has any applicant required the assistance of any other individual for performances of any activities of daily living? If "Yes", please provide name(s) below:

Applicant Name:	
Applicant Name:	

☐ Yes ☐ No m. Is any applicant currently a patient in a hospital or nursing home? If "Yes", please provide name(s) below:

Applicant Name:	
Applicant Name:	

SECTION 12 | APPLICATION METHOD

Select one answer for each question below. Electronically includes via email, fax or online.

1. How was this application received or started?
   ☐ Phone ☐ Face-to-Face ☐ Electronically ☐ Mail
2. How was this application submitted or completed?
   ☐ Phone ☐ Face-to-Face ☐ Electronically ☐ Mail

(Continued on page 4)

SECTION 13 | APPLICANT(S) EMPLOYMENT INFORMATION [applicant(s) age 18 and older]

Name	Employer

Job duties:

Name	Employer

Job duties:

SECTION 14 | 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 15 | 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" to question a. or b., please provide the following:**

Name	Treatment/Procedure:	Date
Name	Treatment/Procedure:	Date

SECTION 16 | TOBACCO USAGE

☐ Yes ☐ No Has any applicants to be covered used **any form of tobacco or nicotine supplements/cessation products** within the last 12 months? If "Yes," please provide the following:

Name	Date Last Used:
Name	Date Last Used:
Name	Date Last Used:

(Continued on page 5)

SECTION 17 | PRESCRIPTION QUESTIONNAIRE

☐ Yes ☐ No Is any applicant **currently** taking any prescription medication, or has any applicant taken prescription medication in the last 7 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		Complete Name and Address of Prescribing Physician
				mo	year	
				mo	year	
				mo	year	
				mo	year	

SECTION 18 | 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.

In the last 7 years, has any applicant had or been told he/she had:

- ☐ Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related Complex (ARC) or Immune Deficiency Disorder or HIV
- ☐ Adrenal disorders
- ☐ Alzheimer's Disease or senile dementia
- ☐ Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
- ☐ Anemia
- ☐ Angina, heart attack, myocardial infarction
- ☐ Arteriosclerosis, atherosclerosis, Coronary Artery Disease, stent placement or angioplasty
- ☐ Attempted suicide
- ☐ Brain and nervous system disorders
- ☐ Cancer, Leukemia, or malignancy of any kind
- ☐ Cardiomyopathy, Enlarged Heart, Congestive Heart Failure
- ☐ Cerebral Palsy
- ☐ Cerebrovascular accident (stroke), including Transient Ischemic Attack (TIA)
- ☐ Chronic fatigue
- ☐ Chronic Obstructive Pulmonary Disease, emphysema, lung disease or Respiratory Syncytial Virus (RSV), sleep apnea
- ☐ Cirrhosis
- ☐ Connective Tissue disorder
- ☐ Crohn's Disease or ulcerative colitis
- ☐ Diabetes, abnormal glucose
- ☐ Dialysis
- ☐ Eyes, Ears, Nose or Throat disorders
- ☐ Fibromyalgia
- ☐ Gastric bypass surgery or other weight loss procedure
- ☐ Gastric or duodenal ulcer
- ☐ Glandular disorders
- ☐ Heart bypass surgery, pacemaker implant
- ☐ Heart or vein/artery surgery
  - ☐ Congenital ☐ Disease
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hodgkin's or Non-Hodgkin's Disease
- ☐ Hypertension
- ☐ Kidney, urinary, or reproductive disorders
- ☐ Lupus, systemic
- ☐ Meniere's Disease
- ☐ Mental disorders
- ☐ Multiple Sclerosis, Muscular Dystrophy, or Myasthenia Gravis
- ☐ Musculoskeletal Disorders
- ☐ Nephritis
- ☐ Nephrotic Syndrome, renal disease or failure
- ☐ Pancreatitis
- ☐ Parkinson's Disease
- ☐ Pending Surgery
- ☐ Polyneuritis
- ☐ Respiratory, digestive or circulatory condition
- ☐ Sarcoidosis
- ☐ Silicone breast implants
- ☐ Sugar, blood, or protein in urine
- ☐ Thyroid disorders
- ☐ Transplant recipient (except cornea/lens)
- ☐ Valve repair/replacement/shunts or stents/retained hardware
  - ☐ Congenital ☐ Disease
- ☐ Any injury, deformity, incapacitation, disease or condition not listed elsewhere
- ☐ Any symptoms, ailments, or concerns needing medical evaluation

☐ **None of the above apply to any applicant(s)**

(Continued on page 6)

SECTION 18 | MEDICAL QUESTIONNAIRE (continued)

ADDITIONAL MEDICAL INFORMATION

Give full details to questions answered affirmatively (checked or answered "Yes") to explain answers to questions in SECTION 17. 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.**

Condition/Illness	Person Treated	Specific Disorder/ Illness	Type of Treatment	Frequency of Treatment	Complete Name and Address of Physician	Date of Last Visit

SECTION 19 | PHYSICIAN INFORMATION (Please provide for each applicant for the last seven years)

Applicant's Name	Complete Name and Address of Physician, Healthcare Provider, and/or Primary Care Physician	Date of Last Visit*	Reason for Last Visit (Condition, Rx, Treatment)

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

(Continued on page 7)

PLEASE READ BEFORE SIGNING

I UNDERSTAND: (1) The agent or broker involved in this insurance transaction may receive compensation from Arkansas Blue Cross and Blue Shield (hereafter referred to as the COMPANY), 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. In signing, I: (a) 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; (b) agree that a photocopy of this application shall be as valid as the original, and I understand that a copy is available to me upon request.

COMPLETE: I UNDERSTAND: (1) This application will be medically underwritten in order to assess the potential financial risk of each individual on the application. As the result of the assessment, my application may be approved with no changes, approved but charged a higher premium, or I may be declined for coverage. (2) Any coverage which may be issued to me shall be invalid if based on intentional misrepresentation of material fact provided by me on the application. (3) Arkansas Blue Cross and Blue Shield (hereafter referred to as the COMPANY) may phone me for additional information that may help with the timely processing of my application. (4) The health insurance applied for will not be effective on any proposed insured if there has been a change in the health of any proposed insured between the date this application is signed and the effective date of coverage. **This application is valid for 45 days only when completed and signed.**

In signing, I: (a) understand that the COMPANY may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if intentional misrepresentations of material fact have been provided by me in this application; (b) understand that if intentionally fraudulent misstatements were made, the COMPANY may take legal action at any time; (c) understand my signature authorizes the COMPANY to coordinate benefits under this policy with other insurance I have which is subject to coordination; (d) agree that this application shall be valid without time limit. 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.

Please read below. Your application will not be accepted unless you check the box confirming you understand the following statement:

☐ **I certify that I am a resident and signed this application in the state of Arkansas.**

SIGNATURE SECTION (Please sign appropriate line only)

Primary Applicant OR Parent/Legal Guardian **(if policy for a minor)**		Date Signed
Spouse **(required if applying)**		Date Signed
Dependent age 18 or older **(required if applying)**		Date Signed
Dependent age 18 or older **(required if applying)**		Date Signed

CUSTODIAL PARENT SECTION

If any applicant under age 18 (primary applicant or dependent), named on this application, does NOT reside with the primary applicant or the parent/guardian indicated in Section 2, the custodial parent's signature is also required.

Custodial Parent's Name **(please print)**	Telephone No.

Custodial Parent's Address	Street or PO Box	City	State	Zip

Custodial Parent's Signature	Date Signed

THIS SECTION TO BE COMPLETED BY SALES REPRESENTATIVE

☐ Yes ☐ No 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?

Sales Rep NPN (required)	Sales Representative's Name (Please Print)	Telephone No.

Agency Federal Tax ID No. (required)	Sales Representative's Signature	Date Signed

Comments:

OFFICE USE ONLY

(Continued on page 8)

PRE-AUTHORIZED BANK DRAFT | Monthly Program Sign-up Form

Our monthly bank draft service makes premium payments easy and convenient for you. Completing this simple form helps assure your payments are made accurately and timely.

Depending on the health insurance plan you are applying for and the date your application is approved, we may be able to draft your first month's premium. If so, you will be notified in writing prior to the draft. Once the bank draft is in effect, you will not receive a billing statement. Until that time, make sure you pay any statement you receive.

Complete the information below.

IMPORTANT: PLEASE READ BEFORE SIGNING

I authorize Arkansas Blue Cross and Blue Shield and/or the BANK indicated below, to debit my Arkansas Blue Cross 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 coverage, UNLESS Arkansas Blue Cross 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.

PROPOSED INSURED'S INFORMATION

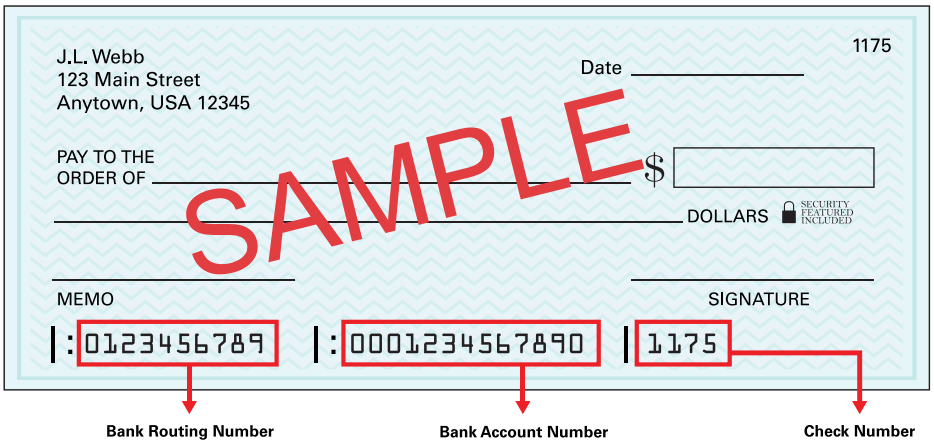
First Name	Last Name

Street address	Apt. No.	City	State	Zip

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!

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

ID NO.	EFFECTIVE DATE

(Continued on page 9)

Please 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, Enterprise Underwriting, P.O. Box 2181, Little Rock, Arkansas 72203-2181.

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