



Arkansas
BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

Individual/Family Health Insurance HEALTH INSURANCE APPLICATION

Gold, Silver and Bronze Plans

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

- **Must be submitted electronically. PDF for recording data only.**
- **Agents are required to keep this application for 10 years.**

NOTE: Additional documentation required should be faxed to Arkansas Blue Cross at 501-378-3752 or emailed to crmcustomerservice@arkbluecross.com immediately following the submission of the application.

SECTION 1 | WHO IS APPLYING?

- The policyholder (the owner of the policy) 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 who is a U.S. Citizen. 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.
- If applying for Individual and Spouse coverage, primary applicant must be age 18 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.
- In "Relationship" box, indicate "spouse, son, daughter, stepson, stepdaughter or dependent child" beside each dependent's name.
- If applying for coverage for dependent child other than son, daughter, stepson, or stepdaughter, submit copy of appropriate dependent documentation (e.g., legal guardianship) when submitting the application.

First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Security No.
				Self			

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 (e.g., legal guardianship) when submitting the application.

First Name	M.I.	Last Name	Relationship (Check One)
			<input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Guardian <input type="checkbox"/> Father <input type="checkbox"/> Stepfather

SECTION 3 | MARITAL STATUS

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

SECTION 4 | 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 requested.
- A person must be lawfully present in the U.S. for the entire period of enrollment.

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: _____

OFFICE USE ONLY (Do not write in this space)

I.D. No.	Group No.	Effective Date
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SECTION 5 | RESIDENTIAL ADDRESS (Must be permanent address – No P.O. box, please)

Street _____ City _____ State _____ Zip _____ County _____

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

Street or P.O. Box _____ City _____ State _____ Zip _____

SECTION 7 | BILLING (Complete only if different from residential address)

Street or P.O. Box _____ City _____ State _____ Zip _____

SECTION 8 | CONTACT INFORMATION*

Primary Phone Number ()	Alternate Phone Number ()	E-mail
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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.

SECTION 9 | HOUSEHOLD INFORMATION

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

SECTION 10 | CURRENT/PREVIOUS 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 and phone number of carrier:
 () _____
 ii. If "yes," does the coverage have a specified termination date? If so, please provide date: ___/___/___
 iii. Is this coverage ending due to nonpayment of premiums? Yes No
 iv. 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
 v. Is this a limited benefit plan like a short-term or accident policy? Yes No

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 # _____

SECTION 10 (continued) | CURRENT/PREVIOUS INSURANCE COVERAGE

- 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 11 | POLICY ELIGIBILITY

Check all applicable boxes below that support your eligibility to apply for this policy and – if applicable – provide date of qualifying life event.

- | | Date | | Date | | Date |
|--|---------------------|---|-------|--|-------|
| <input type="checkbox"/> 1–Annual Open Enrollment Period: | <u>11/1 – 12/15</u> | <input type="checkbox"/> 8–Loss of Minimum Essential Coverage | _____ | <input type="checkbox"/> 11–Errors, misinterpretation, in action by the Exchange, HHS, or their agents | _____ |
| <input type="checkbox"/> 2–Birth | _____ | <input type="checkbox"/> 9–Non-calendar Year Policy expires outside OEP (This is a one-time SEP, which will be used for those losing coverage due to the expiration of a non-grandfathered policy.) | _____ | <input type="checkbox"/> 12–QHP Contract Violation in relation to an individual | _____ |
| <input type="checkbox"/> 3–Adoption | _____ | <input type="checkbox"/> 10–New coverage becoming available as a result of a permanent move | _____ | <input type="checkbox"/> 13–Loss of eligibility for APTC | _____ |
| <input type="checkbox"/> 4–Death | _____ | | | <input type="checkbox"/> 14–Same sex marriage | _____ |
| <input type="checkbox"/> 5–Marriage | _____ | | | <input type="checkbox"/> 15–Eligible for other coverage | _____ |
| <input type="checkbox"/> 6–Divorce or Legal Separation | _____ | | | <input type="checkbox"/> 16–Other (Give specific details and date) | _____ |
| <input type="checkbox"/> 7–New Guardianship/ Legal Custody/ Court Order to add child | _____ | | | | |

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 from previous insurance company, legal guardianship/custody documentation, etc.) no greater than 60 days before triggering event and no later than 60 days after triggering event, except in the case of birth where the application must be received no later than 90 days after birth. Birth certificate required **only** if newborn (child 0-90 days old, as of received date) is not applying for coverage.

SECTION 12 | TOBACCO USAGE

- Yes No Does any enrollee that will be covered currently use any form of tobacco?
 Name: _____

SECTION 13 | PRIMARY CARE PHYSICIAN(S) (Please list for each applicant)

Applicant	PCP First Name	PCP Last Name	PCP City	PCP State	PCP Zip

SECTION 14 | PLAN SELECTION

MUST CHOOSE ONE BOX ONLY

GOLD

- Plan 1
- HSA 1

SILVER

- Plan 1
- Plan 2
- Plan 3
- Plan AW1
- HSA 1

BRONZE

- Plan 1
- Plan 2
- HSA 1

SECTION 15 | POLICYHOLDER PROXY AND MEMBER INFORMATION

As a Policyholder, you are a member of Arkansas Blue Cross and Blue Shield. By accepting this Policy you appoint the Board of Directors ("Board") of the Company to act on your behalf at all meetings of Members of the Company. This appointment shall include such persons as the Board may designate by resolution to act on its behalf. This proxy gives the Board, or its designee, full power to vote for you on all matters that may be voted upon at any meeting. The annual meeting of Members is held each year at the home office of Arkansas Blue Cross and Blue Shield located at 601 S. Gaines Street, Little Rock, Arkansas, on the third Monday of March, at 1:00 p.m. If the third Monday of March is a legal holiday, then the meeting will be at the same time and place on the next day after, which is not a legal holiday. A special meeting may be called upon notice mailed not less than ten (10) or more than sixty (60) days prior to such meeting. This proxy, unless revoked, shall remain in effect during the term of this Policy. You may revoke this proxy in writing by advising the Company of such revocation at least five (5) days prior to any meeting. You may also revoke its proxy by attending and voting in person at any Members' meeting.

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. (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) The COMPANY may phone me for additional information that may help with the timely processing of my application.

In signing below, 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) 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; (e) 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. **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.

This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. The coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact Arkansas Blue Cross and Blue Shield or your agent if you wish to purchase pediatric dental coverage or a stand-alone services product.

Rates are based on where you and any covered dependents live in Arkansas and tobacco use.

Arkansas Blue Cross and Blue Shield does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

SIGNATURE SECTION | (Please sign appropriate line only)

Primary Applicant OR Parent Legal/Guardian (if policy for a minor)	(Please Sign) X	Date Signed
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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 License or NPN (required)	Sales Representative's Name (Please Print) X	Telephone No.
Agency Federal Tax ID No. Date Signed (If applicable)	Sales Representative's Signature X	Date Signed
Comments:		OFFICE USE ONLY

THIS APPLICATION IS VALID FOR 90 DAYS ONLY WHEN COMPLETED AND SIGNED.

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

POLICY EFFECTIVE DATE

Applications received and approved as a result of Open Enrollment (November 1 through December 15) will have an effective date of January 1 of the following year. Applications received and approved as a result of a life event will have an effective date based on the received date of the application and the life event/eligibility reason. Some exceptions apply. Coverage becomes effective upon the date of the policy and is contingent upon receipt of premium.

REMINDERS

To ensure your application is processed as quickly as possible, make sure:

- All questions are answered.
- All the pages are returned.
- All appropriate signatures and signature dates are provided.

Important Note: Depending on the date your application is approved, we may not be able to draft your first premium payment. To ensure coverage, please promptly pay any invoice you receive.



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