Health Advantage

An Independent Licensee of the Blue Cross and Blue Shield Association

Individual/Family Health Coverage 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.
- **What changes would you like to make?**
  - **Contact information** ➡ Complete sections 1 and 2
  - **Address change** ➡ Complete sections 1, 2 and 3
  - **Name change** ➡ Complete sections 1, 2 and 5
  - **Delete person from evidence of coverage** ➡ Complete sections 1, 2, 4 and 6
  - **Add person to evidence of coverage** ➡ Complete sections 1, 2, 4, 7, 8, 9, 10 and 13
  - **Make someone else the primary subscriber** ➡ Complete sections 1, 2, 4, 7, 8, 9, 10 and 11
  - **Split my evidence of coverage into two or more policies** ➡ Complete sections 1, 2, 4, 7, 8, 9, 10 and 12

INSTRUCTIONS

Changes to your evidence of coverage can only be made during the annual open enrollment period, unless the change is a result of a special election period or a qualifying life event, such as birth of a child, adoption, loss of other coverage, marriage, etc.

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

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.**

NOTE: Additional documentation required should be faxed to Customer Service at **501-378-3752** or emailed to **crmcustomerserviceHA@healthadvantage-hmo.com** immediately following the submission of the application.

Health Advantage

CHANGE FORM

Return To: Health Advantage
Attn: CRM Operations and Service
P.O. Box 2181
Little Rock, AR 72203-2181

OR Fax to: 501-378-3752
E-mail: crmcustomerserviceHA@healthadvantage-hmo.com

SECTION 1 | CURRENT SUBSCRIBER INFORMATION

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

First Name: _____ M.I.: _____ Last Name: _____

SECTION 2 | CONTACT INFORMATION*

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

How do you prefer we communicate with you? ☐ E-mail ☐ Phone

*Health Advantage 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 or Health Advantage.

CHANGES TO BE MADE – *Please skip sections that do not apply to the change(s) you are making.*

SECTION 3 | ADDRESS CHANGES

Any change to your current address information can be completed below. 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 Personal Health Statements (PHSs) will be mailed to this address.

Billing – All billing invoices will be mailed to this address.

A person must be lawfully present in the U.S. for the entire period of enrollment.

Residential Address: Street _____

City _____ State _____ Zip _____

Mailing Address: Street _____

City _____ State _____ Zip _____

Billing Address: Street _____

City _____ State _____ Zip _____

NOTE: If the only change you want to make is an address change, you are not required to submit a Change Form. You may simply call Customer Service at **1-800-800-4298,** and a representative can change your address quickly and easily.

SECTION 4 | EVIDENCE OF COVERAGE CHANGE ELIGIBILITY

Qualifying life event changes allow you to make changes to your evidence of coverage outside of the annual open enrollment period. **Please ensure all documentation is included.** Such events include, but are not limited to:

- Divorce/Legal Separation (requires a copy of divorce decree/legal separation)
- No longer an Arkansas resident (requires a date of move or date of notification)
- Marriage (requires a copy of the marriage certificate and proof of loss of minimum essential coverage)
- Becoming eligible for other coverage (requires proof of eligibility of other coverage)
- Death (requires a copy of death certificate)

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

	Date		Date		Date
☐ 1–Annual Open Enrollment Period:	11/1 – 12/15	☐ 8–Loss of Minimum Essential Coverage	_____	☐ 11–Errors, misinterpretation, in action by the Exchange, HHS, or their agents	_____
☐ 2–Birth	_____	☐ 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.)	_____	☐ 12–QHP Contract Violation in relation to an individual	_____
☐ 3–Adoption	_____			☐ 13–Loss of eligibility for APTC	_____
☐ 4–Death	_____			☐ 14–Same sex marriage	_____
☐ 5–Marriage	_____			☐ 15–Eligible for other coverage	_____
☐ 6–Divorce or Legal Separation	_____			☐ 16–Other (Give specific details and date)_____	_____
☐ 7–New Guardianship/ Legal Custody/ Court Order to add child	_____	☐ 10–New coverage becoming available as a result of a permanent move	_____		

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 5 | NAME CHANGE

Documentation is required for any name change request. Please complete and attach appropriate documentation such as a copy of your marriage license, divorce decree, adoption papers or other court papers to support the change.

From: First Name _____ M.I. _____ Last Name _____

To: First Name _____ M.I. _____ Last Name _____

SECTION 6 | DELETE PERSON(S) FROM THE EVIDENCE OF COVERAGE

In the event you would like to **terminate coverage** for a member, including the subscriber, you can do so by completing this section.

OR

You have the option to **maintain the person's coverage** by splitting him/her off onto a new individual evidence of coverage with identical coverage. This will completely remove him/her from your coverage and create a new evidence of coverage for the member. You can make this change by completing **Section 12 – Split Evidence of Coverage.** A signature is **required** by **both** the current subscriber and new subscriber.

Important Note: Complete one change form for each new evidence of coverage you are requesting.

First Name	M.I.	Last Name	Suffix	Reason

 (Continued on page 3)

SECTION 7 | ADDING SPOUSE OR DEPENDENT(S)

Qualifying life event changes allow you to make changes to your evidence of coverage 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)
- Marriage (requires a copy of the marriage certificate)

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

SECTION 8 | 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: _____

Name: _____

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 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. If "yes," and the coverage does not have a specified termination date, will the coverage terminate if approved 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 11 | OWNERSHIP CHANGE

If both the subscriber and spouse are retaining coverage, but you would like to change the ownership of the evidence of coverage from the current subscriber to the spouse, complete this section. **Both the current subscriber and new subscriber must sign the change form.**

From: First Name _____ M.I. _____ Last Name _____

To: First Name _____ M.I. _____ Last Name _____

SECTION 12 | SPLIT EVIDENCE OF COVERAGE

Indicate the name of the member you want covered on a separate evidence of coverage with identical coverage.

First Name	M.I.	Last Name	Suffix	Date of Event

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

Please provide address information for new Subscriber ONLY:

Residential Address: Street _____
City _____ State _____ Zip _____

Mailing Address: Street _____
City _____ State _____ Zip _____

Billing Address: Street _____
City _____ State _____ Zip _____

SECTION 13 | TOBACCO USAGE

☐ Yes ☐ No Does any new or existing member currently use any form of tobacco?

Name(s): _____

PLEASE READ BEFORE SIGNING

I UNDERSTAND: (1) The agent or broker involved in this insurance transaction may receive compensation from Health Advantage, or one of its affiliates, for services related to the placement of this health plan. Any such compensation is included in the premium paid by the subscriber. 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) Health Advantage 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, Health Advantage may take legal action at any time; (c) understand my signature authorizes the Health Advantage to coordinate benefits under this evidence of coverage 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 evidence of coverage 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 Health Advantage 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.

Health Advantage 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)

Current Subscriber **OR** Parent Legal/Guardian (if evidence of coverage for a minor)	(Please Print) **X** Date	**OFFICE USE ONLY**
	(Please Print) **X** Date	
New Subscriber	(Please Print) **X** Date	

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