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

Vision Classic, Plus or Select Change Form

Return To: Arkansas Blue Cross and Blue Shield, Attn: Change Request, P.O. Box 2181, Little Rock, AR 72203-2181
or Fax to: 501-378-3752 or email to: CRMCustomerService@arkbluecross.com

1 CURRENT POLICYHOLDER INFORMATION

Member ID	Group Number	Date of Birth:

First Name	M.I.	Last Name

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

CHANGES TO BE MADE

Please skip sections that do not apply to the change(s) you are making.

2 ADDRESS CHANGES

Residential

Street	City	State	County	Zip

Mailing

Street	City	State	County	Zip

Billing

Street	City	State	County	Zip

3 NAME CHANGE

From: First Name	M.I.	Last Name

To: First Name	M.I.	Last Name

Is this name change as a result of a marriage?			Is this name change as a result of a divorce?		
☐ Yes	☐ No	Marriage Date:	☐ Yes	☐ No	Divorce Date:

Other reason for change

Date of change:

4 BILLING CHANGE

☐ Monthly Bank Draft (Must complete attached bank draft form) ☐ Monthly Direct Billing (Paper bill)

5 DELETE PERSON(S) FROM THE POLICY

First Name	M.I.	Last Name	Suffix	Date of Birth	**Reason Code* (see below)**	Date of Event

***Reason Codes:** 1 - Divorce 2 - Aging Off 3 - Marriage 4 - Death 5 - Other

(Continued on page 2)

6 OWNERSHIP CHANGE

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

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	**Reason Code* (see below)**	Date of Event

***Reason Codes:** 1-Divorce 2-Aging Off 3-Marriage 4-Other (specify above)

Please provide address information for new policyholder ONLY:

Residential

Street	City	State	County	Zip

Mailing

Street	City	State	County	Zip

Billing

Street	City	State	County	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)

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	

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.

(Continued on page 3)

9 ADDING SPOUSE OR DEPENDENT(S) *(Continued)*

☐ Yes ☐ No Are all applicants permanent, legal residents of Arkansas? If "no," please provide:

Name	
Address	
Reason	

☐ Yes ☐ No Have any of the proposed insureds had any other vision 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) We will not refund any part of your premium except in the event of a death of the policyholder. Once you have been accepted and payment has been received, the premium will not be refunded for any reason other than the death of the policyholder. (4) 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. (5) 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. (6) Arkansas Blue Cross and Blue Shield may phone me for additional information that may help with the timely processing of my application. (7) In general, members who enroll in Vision coverage and terminate the coverage before the end of the plan year (the 12-month period beginning with the effective date of their coverage) will be ineligible to reapply until 12 months after the termination date. However, if the member wishes to reapply within 12 months of the termination date and can provide proof of creditable coverage under another Vision plan, this provision may be waived, allowing the member to reapply. 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)**		Date Signed
New Policyholder		Date

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 Office Use Only (Do not write in this space.)

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 ensure your payments are made accurately and timely.

Important: Please Read Before Signing

I authorize Arkansas Blue Cross and Blue Shield and 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

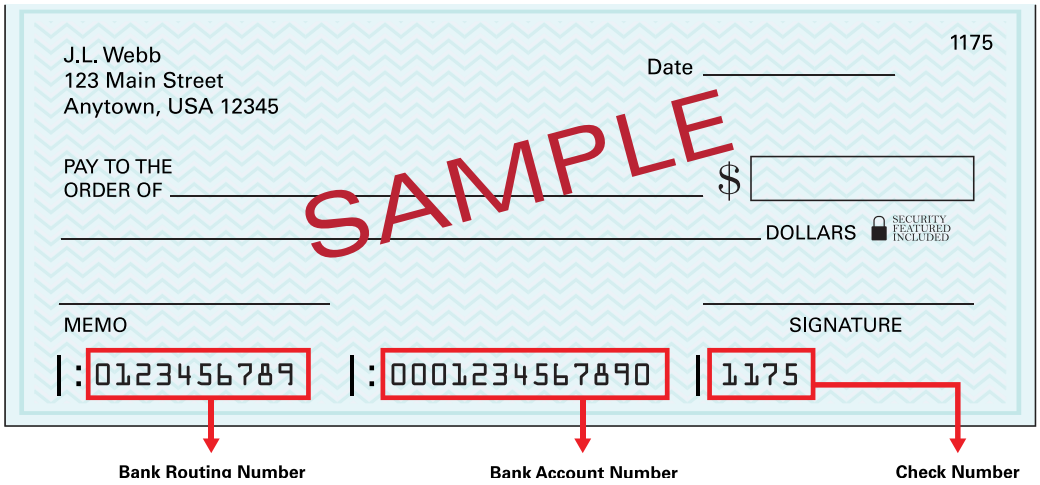
First Name	Last Name

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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ID NO.	EFFECTIVE DATE