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: ____________

Email Address: ____________

CHANGES TO BE MADE

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

2 ADDRESS CHANGES

Residential Address: Street ____________
City ____________ State______ Zip______

Mailing Address: Street ____________
City ____________ State______ Zip______

Billing Address: Street ____________
City ____________ State______ 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? ☐ Yes ☐ No Marriage Date: ____/____/______

Is this name change as a result of a divorce? ☐ 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 Change

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

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6 OWNERSHIP CHANGE

From: First Name______________________ M.I.______ Last Name______________________

To: First Name______________________ M.I.______ Last Name______________________

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 Change

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

Please provide address information for new policyholder ONLY:

Residential Address: Street ______________________________________

City ______________________ State______ Zip __________

Mailing Address: Street ______________________________________

City ______________________ State______ Zip __________

Billing Address: 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)

8 U.S. CITIZENSHIP STATUS

Additional information may be required.

Are all applicants U.S. citizens? ☐ Yes ☐ No

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.

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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:___/___/___

Name:____________________________________ Effective Date:___/___/___ Termination Date:___/___/___

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's **(if policy for a minor)**	**X**	Date Signed
New Policyholder	**X**	Date

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:______________________

Address: ____

Street 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______________________ Date______________________

Signature of Bank Account Holder

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

Form ID OE Vision CF (R09/19)