Non-underwriting | 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, even if they are blank, 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.
- **What changes would you like to make?**
  - **Contact information:** Complete sections 1, 2 and 3
  - **Address change:** Complete sections 1, 2, 3 and 4
  - **Name change:** Complete sections 1, 2, 3 and 5
  - **Delete person from policy:** Complete sections 1, 2, 3 and 6
  - **Make someone else the primary policyholder:** Complete sections 1, 2, 3 and 7
  - **Split my policy into two or more policies:** Complete sections 1, 2, 3 and 8
  - **Delete/Change benefits:** Complete sections 1, 2, 3, 9 and/or 10

Instructions

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

Effective Date: Changes will become effective on the 1st of the month. The effective date for any changes will be the next available effective date following approval, unless otherwise requested. Once your changes are approved, we will attempt to contact you to find out what effective date you would like.

Section 1 | Current policyholder information

Member ID	Group number	Date of birth

First name	Middle initial	Last name

Section 2 | Contact information

Primary phone number	Alternate phone number	Email address

How do you prefer we communicate with you? ☐ Phone ☐ Email

Note: By selecting your preferred contact method, you agree that all communication during the application process will be sent based on your selection; however, the alternate method(s) may be used if needed to reach you for purposes related to your application..

☐ **Important Opt-In Consent for Electronic Document Access and Delivery:** By providing your email address or by checking this box, you agree that after enrollment we may communicate with you and provide your policy information to you electronically for your convenience, such as your health insurance plan documents, benefits, ID cards, explanation of benefits, claim status, and legal notices regarding your financial, privacy and healthcare rights under federal law. Opting into electronic delivery also allows us to communicate with you electronically, either directly or through one of our contracted business associates, regarding your plan, identification of healthcare providers participating in our networks, disease management, health education and health promotion, preventive care options, wellness programs, treatment options, care coordination, and case management assistance for you in connection with your plan through [Arkansas Blue Cross Blue Shield, Health Advantage, Octave Blue Cross and Blue Shield or Skai Blue Cross and Blue Shield] ("Plan"). Please note that you are responsible for updating your contact information. This electronic delivery will continue through any policy renewals or other changes. Once you are an enrolled member of a plan, if you want to change your communication preferences, including to opt-out of electronic delivery, you may:

- Update your communication preferences and/or contact information at **blueprintportal.com**

OR

- Call the Customer Service number located on your member ID card

If you register for Blueprint portal access after enrollment, this allows you to access your documents and information electronically through your own password-protected account. With the Blueprint portal, your documents can be viewed or printed using your computer or mobile device. The website may be accessed with most versions of Chrome, Firefox, Microsoft Edge, or Safari. You may also set your preferences at **blueprintportal.com**.

Consent to electronic delivery is not a condition of purchase, enrollment, or coverage. At no cost to you, you also may request a paper copy of a document, regardless of whether it is or has been delivered electronically.

By providing your mobile phone number, you agree that automated, informational text messages may be sent to you by or on behalf of your Plan to update you about new plan products and programs. You can opt-out of receiving such text messages at any time by responding STOP in a response text message. Standard mobile phone and/or text message charges may apply from your wireless provider. Frequency will vary.

Section 3 | Requested effective date

What would you like your effective date to be? (Note: Changes can only become effective on the 1st of the month, unless change is due to birth or adoption.

Month	Day	Year		Month	Day	Year
	01		☐ Birth/Adoption			

Changes to be made

You may skip section(s) that do not apply to the change(s) you are making.
However, you must return all pages — even if blank.

Section 4 | Address changes

Any change to your current address information can be completed in this section. We have provided three separate listings for this information. 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 Explanation of Benefits will be mailed to this address.
Billing – All billing invoices will be mailed to this address.

Residential street	**City**	**State**	**ZIP**
Mailing street	**City**	**State**	**ZIP**
Billing street	**City**	**State**	**ZIP**

Section 5 | Name change

Documentation is required for any name change request. Please complete this section 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**	**Middle initial**	**Last name**
To:	**First name**	**Middle initial**	**Last name**

Section 6 | Delete person(s) from the policy

In the event you would like to **terminate coverage** for a covered person, including the primary policyholder, you can do so by completing this section, **OR** you have the option to **maintain coverage on the person you would like to delete from your policy** by splitting him/her off onto a new individual policy with identical coverage. This will completely remove him/her from your coverage and create a new policy for the covered person. You can make this change by completing **Section 8 – Split Policy.** A signature is **required** by **both** the current policyholder and the person maintaining their coverage and moving to a new policy of their own.

Important Note: Complete one change form for each new policy you are requesting

First name	M.I.	Last name	Suffix	Reason	Date of event

Section 7 | Ownership change

Complete this section only when the primary policyholder is being removed. **Both the current policyholder and new policyholder must sign the change form.**

From:	**First name**	**M.I.**	**Last name**
To:	**First name**	**M.I.**	**Last name**

Section 8 | 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 event

Primary phone	Alternate phone	Email

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**

Section 9 | Delete benefits (see products in Section 10 for other optional riders)

☐ Term Life Insurance ☐ Maternity Rider ☐ Mental Health Parity

(Only applicable for Comprehensive Blue PPO and Comprehensive Blue PPO II)

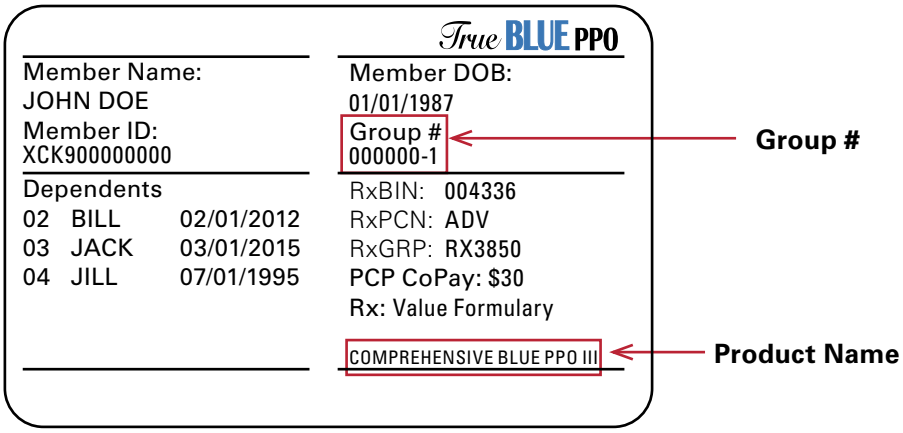
Section 10 | Benefit changes

IMPORTANT NOTE: Increasing the calendar-year deductible means that any claims processed by Arkansas Blue Cross after the effective date of change, regardless of the date of the service(s), will be applied to the new higher deductible.

- This section reflects all benefit options available for **all** of our individual policies.
- **Please complete only the section for your specific policy.**
- If you are unsure of your product name, use the product group numbers listed as a reference. Your product group number can be found on your identification card under **Group #.** It will be the first six numbers before the dash.
- If you still have questions, call Customer Service at **1-800-238-8379.**

IMPORTANT NOTE: Increasing the calendar-year deductible means that any claims processed by Arkansas Blue Cross after the effective date of change, regardless of the date of the service(s), will be applied to the new higher deductible.

Sample Identification Card



- **BLUECARE PPO PLUS**
  Your Group # on your ID card will be one of these:
  600030-600036 (grandfathered)
  Increase my calendar-year deductible to: ☐ $1,000 ☐ $1,500 ☐ $2,500*
  Increase my calendar-year coinsurance maximum to: ☐ $2,000
  *Calendar-year coinsurance not applicable for $2,500 deductible

- **BLUE CHOICE**
  Your Group # on your ID card will be one of these:
  771000-771123 (grandfathered)

  Increase my calendar-year deductible and benefit to:

  $500 Deductible options
  ☐ $2,000 out-of-pocket coinsurance maximum

  $1,000 Deductible options
  ☐ $1,000 out-of-pocket coinsurance maximum
  ☐ $2,000 out-of-pocket coinsurance maximum

  $2,500 Deductible options
  ☐ No out-of-pocket coinsurance
  ☐ $2,000 out-of-pocket coinsurance maximum

  $5,000 Deductible Options
  ☐ $30/$50 copay ☐ No physician copays*

  $10,000 Deductible options
  ☐ $30/$50 copay ☐ No physician copays*

  $25,000 Deductible options
  ☐ $30/$50 copay ☐ No physician copays*

  *Physician visits subject to deductible.

IMPORTANT NOTE: Increasing the calendar-year deductible means that any claims processed by Arkansas Blue Cross after the effective date of change, regardless of the date of the service(s), will be applied to the new higher deductible.

- **BLUE SOLUTION**
  Your Group # on your ID card will be one of these:
  780000-780003 (grandfathered)
  Increase my calendar-year deductible to: ☐ $1,500 ☐ $3,000 ☐ $5,000

- **COMPREHENSIVE BLUE PPO**
  Your Group # on your ID card will be one of these:
  390000 – 390007 or **391000 – 398000** (non-grandfathered)
  790000 – 790007 or **791000 – 798000** (grandfathered)
  Increase my calendar-year deductible to:
  ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000

- **COMPREHENSIVE BLUE PPO III**
  Your Group # on your ID card will be one of these:
  790008-790016 (non-grandfathered)
  Increase my calendar-year deductible to:
  ☐ $1,500 ☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000

Please read before signing

I understand: (1) This application may be rejected if the applicant is age 18 or older. (2) 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. (3) 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. (4) If my application is accepted relying on my representations in this document, any coverage which may be issued to me shall be invalid if based on intentional misrepresentations of material fact or fraud. (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. In signing below, I 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.

You may review our privacy and non-discrimination notices at **arkbluecross.com/privacy**, **arkbluecross.com/financial-privacy** and **arkbluecross.com/notice**.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Arkansas Blue Cross and Blue Shield, its affiliates and partners may contact you, either directly or through a business associate, using your email address or telephone number regarding your health insurance plan or other promotional opportunities. You can manage your preferences or unsubscribe in Blueprint Portal at **blueprintportal.com**.

I certify that I signed this change form in the state of Arkansas.

Signature section (please sign appropriate line only)

Current policyholder (required if policyholder is age 18 or older) **OR parent/legal guardian** (if policy for a minor)

Please print	Please sign	Date signed

New policyholder (If splitting a policy or changing the policyholder)

Please print	Please sign	Date signed

Office use only

This application is valid for 90 days only when completed and signed.

IMPORTANT INFORMATION REGARDING GRANDFATHERED PLANS

Your Arkansas Blue Cross and Blue Shield coverage may be a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Arkansas Blue Cross and Blue Shield Customer Service at **1-800-238-8379**. You may also contact the U.S. Department of Health and Human Services at **www.healthcare.gov**.

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.

Return to:
Arkansas Blue Cross and Blue Shield
Attn: CRM Operations and Service
P.O. Box 2181
Little Rock, AR 72203-2181

OR

Fax to: **501-378-3752**
E-mail: **CRMCustomerService@arkbluecross.com**

Pre-authorized bank draft | Monthly program sign-up form

Our monthly bank draft service makes premium payments easy and convenient for you. Just a few steps now help assure your payments are made accurately and timely.

1. **Complete the information below.**
2. **Mail this completed authorization form to:**

   Arkansas Blue Cross and Blue Shield
   Attn: Cashiers (Drafts)
   P.O. Box 3590
   Little Rock, AR 72203

Important: Please read before signing

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

Insured's information

First name	Last name			
Street address	**Apt. no.**	**City**	**State**	**ZIP**

Arkansas Blue Cross and Blue Shield member ID

Please check one of the following:

☐ Currently, the insured's premium is **not** drafted.

☐ Currently, the insured's premium is drafted and the account information has changed.

Bank account information

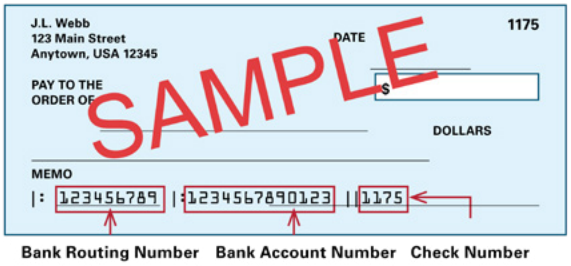
Bank name

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!

For office use only
(please do not write in this space)

ID No.
Effective date

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

USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products. USAble Life is solely responsible for the term life and critical illness policies referenced in your policy.

NOTICE OF LANGUAGE ASSISTANCE, AUXILIARY AIDS/SERVICES AND NON-DISCRIMINATION NOTICE

We provide free language assistance, appropriate auxiliary aids and services, and reasonable modifications to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in various formats (large print, audio, accessible electronic formats, other formats), and language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call or contact Customer Service at 1-800-238-8379 (TTY:771) or Civil Rights Coordinator.

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in assessable formats are available free of charge. Call 1-800-238-8379 (TTY: 711) or speak to your provider.

Spanish: ATENCIÓN: Disponemos de servicios gratuitos de asistencia lingüística. También hay disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-238-8379 (TTY: 711) o hable con su proveedor.

Chinese Simplified: 注意：提供免费语言服务。此外，免费提供适合残障人士使用的辅助和支持服务。请致电 1-800-238-8379 (TTY: 711)或联系您的服务提供商。

Chinese Traditional: 注意：我們提供免費的語言協助服務，以及免費的適當輔助工具和其他服務，讓您能夠獲得無障礙格式的資訊。請撥打 1-800-238-8379 (TTY: 711)或諮詢您的服務提供者。

Tagalog: PAUNAWA: Available para sa iyo ang mga libreng serbisyo sa tulong sa wika. Available rin nang walang bayad ang mga naaangkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-238-8379 (TTY: 711) o makipag-usap sa iyong provider.

French: ATTENTION : Des services d'assistance linguistique sont gratuitement mis à votre disposition. Des aides et services auxiliaires appropriés visant à vous informer dans des formats accessibles sont également mis à votre disposition gratuitement. Appelez le 1 800 238 8379 (TTY : 711) ou discutez avec votre prestataire.

Vietnamese: CHÚ Ý: Các dịch vụ hỗ trợ ngôn ngữ sẽ được cung cấp miễn phí cho quý vị. Các dịch vụ và hỗ trợ giao tiếp phù hợp nhằm cung cấp thông tin ở các định dạng dễ tiếp cận cũng được cung cấp hoàn toàn miễn phí. Hãy gọi 1-800-238-8379 (TTY: 711) hoặc trao đổi với nhà cung cấp của quý vị.

German: HINWEIS: Ihnen stehen kostenlose Sprachmittlungsdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zum barrierefreien Zugang zu Informationen stehen ebenfalls kostenfrei zur Verfügung. Rufen Sie 1-800-238-8379 (TTY: 711) an oder sprechen Sie mit Ihrem Leistungserbringer.

Korean: 주의: 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 제공됩니다. 1-800-238-8379 (TTY: 711)번으로 전화하거나 담당 서비스 제공자에게 문의하십시오.

Russian: ВНИМАНИЕ! Вам доступны бесплатные услуги языковой поддержки. Приемлемые вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-238-8379 (TTY: 711) или обратитесь к своему поставщику услуг.

Arabic: ملاحظة: خدمات المساعدة اللغوية متاحة لك مجاناً، كما أن وسائل وخدمات المساعدة الإضافية المناسبة لتوفير المعلومات بصيغ يسهل عليك الوصول إليها متاحة مجاناً أيضاً. يرجى الاتصال على الرقم: 1-800-238-8379 (TTY: 711) أو التحدث إلى مقدم الرعاية

Hindi: ध्यान दें: आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। आसान फ़ॉर्मैट में सूचना उपलब्ध कराने के लिए उचित सहायक साधन और सेवाएं भी निःशुल्क उपलब्ध हैं। 1-800-238-8379 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Italian: ATTENZIONE: Ha a disposizione servizi di assistenza linguistica gratuiti. Potrà usufruire gratuitamente anche di sussidi e servizi ausiliari appropriati per ottenere le informazioni in formati accessibili. Chiami il numero 1-800-238-8379 (TTY: 711) o chieda al suo operatore sanitario.

Portuguese: ATENÇÃO: Serviços gratuitos de assistência linguística estão disponíveis para você. Ajudas e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-238-8379 (TTY: 711) ou fale com seu provedor.

French Creole: ATANSYON: Genyen sèvis asistans lang gratis disponib pou ou. Epitou, genyen lòt èd ak sèvis apwopriye disponib gratis pou ede moun jwenn enfòmasyon nan yon fòma ki aksesib. Rele 1-800-238-8379 (TTY: 711) oswa pale ak founisè w la.

Polish: UWAGA: może Pan/Pani skorzystać z bezpłatnych usług pomocy językowej. Odpowiednie dodatkowe pomoce i usługi w zakresie zapewniania dostępu do informacji w przystępnym formacie również są dostępne bezpłatnie. Prosimy dzwonić pod numer 1-800-238-8379 (TTY: 711) lub porozmawiać z lekarzem.

Japanese: 注意：無料の言語サポートサービスをご利用いただけます。アクセシブルなフォーマットで情報を提供するための適切な援助やサービスも無料でご利用いただけます。1-800-238-8379（TTY：711）にお電話いただくか、医療提供者にご相談ください

NON-DISCRIMINATION NOTICE

Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex.

If you believe that we have failed to provide these language assistance or auxiliary aids and services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex.

Civil Rights Coordinator
601 Gaines Street, Little Rock, AR 72201
Phone: 1-844-662-2276 (TTY: 711)
You can file a grievance in person, by mail, or by email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201
Phone: 1-800-368-1019; TDD: 1-800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.