



# Individual/Family Health Insurance 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 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.



## 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:** The effective date for any changes will be the next available effective date following approval, unless otherwise requested.

**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

**Changes to your policy can only be made during the annual open enrollment period (October 1-December 15), unless the change is a result of a qualifying life event such as birth of a child, adoption, loss of other coverage, marriage, etc.**

## SECTION 1 | CURRENT POLICYHOLDER INFORMATION

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

Member ID: \_\_\_\_\_ Group Number: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Residential Address: Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## SECTION 2 | CONTACT INFORMATION\*

Primary Phone Number ( )	Alternate Phone Number ( )	E-mail Address	How do you prefer we communicate with you? <input type="checkbox"/> E-mail <input type="checkbox"/> Phone
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\*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 or Health Advantage.

## SECTION 3 | 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 required with the application.
- Applicants must reside in the U.S. at least one year and must have a primary care physician in the U.S. prior to being eligible to apply for coverage.
- Applicants who are not U.S. citizens may be contacted by phone to complete a Foreign National Questionnaire.

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: \_\_\_\_\_

### CHANGES TO BE MADE

Please review **all** sections and answer **all** applicable questions.

## SECTION 4 | POLICY CHANGE ELIGIBILITY

Check all applicable boxes below that support your eligibility and provide date of qualifying life event.

	Date		Date		Date
<input type="checkbox"/> 1—Annual Open Enrollment Period:	10/1 – 12/15	<input type="checkbox"/> 7—New Guardianship/Legal Custody/	_____	<input type="checkbox"/> 10—Military Leave	_____
<input type="checkbox"/> 2—Birth	_____	Court Order to Add Child	_____	<input type="checkbox"/> 11—Military Reinstatement	_____
<input type="checkbox"/> 3—Adoption	_____	<input type="checkbox"/> 8—Loss of employer-sponsored	_____	<input type="checkbox"/> 12—Eligible for other coverage*	_____
<input type="checkbox"/> 4—Death	_____	health coverage*	_____	<input type="checkbox"/> 13—Other (Give specific	_____
<input type="checkbox"/> 5—Marriage	_____	<input type="checkbox"/> 9—Involuntary loss of other health	_____	details and date)	_____
<input type="checkbox"/> 6—Divorce or Legal Separation	_____	coverage*	_____		

**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 or attestation from previous insurance company, legal guardianship/custody documentation, etc.).

\*If you are adding a spouse or dependent who is losing coverage of an existing insurance, please apply prior to the current policy end date to avoid a lapse in coverage. Please refer to Section 7 for more details.

**SECTION 5 | POLICY APPEALS**

- Request for Reinstatement: \_\_\_\_\_
- Remove Tobacco Surcharge: Name \_\_\_\_\_ Date Quit: \_\_\_\_/\_\_\_\_/\_\_\_\_
- Remove Other Surcharge: Name \_\_\_\_\_
- Remove Exclusion: Name \_\_\_\_\_ Excluded Condition \_\_\_\_\_  
Name \_\_\_\_\_ Excluded Condition \_\_\_\_\_

**SECTION 6 | ADD SPOUSE OR DEPENDENT(S)**

Qualifying life event changes allow you to make changes to your policy 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 referred to as COCC or attestation)
- Marriage (requires a copy of the marriage certificate)

First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Security No.	Height	Weight
								___ ft. ___ in.	_____ lbs.
								___ ft. ___ in.	_____ lbs.
								___ ft. ___ in.	_____ lbs.
								___ ft. ___ in.	_____ lbs.

**SECTION 7 | CURRENT 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 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 by Arkansas Blue Cross 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 8 | HOUSEHOLD INFORMATION

- Yes  No a. Do all applicants under the age of 19 reside in the same household?  
If "no," please provide reason and his/her name and address:  
Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Reason: \_\_\_\_\_
- Yes  No b. Are all applicants permanent, legal residents of Arkansas?  
If "no," please provide reason and his/her name and address:  
Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Reason: \_\_\_\_\_

## SECTION 9 | APPLICANT(S) EMPLOYMENT INFORMATION [applicant(s) age 18 and older]

Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
Job Duties: \_\_\_\_\_  
Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
Job Duties: \_\_\_\_\_

## SECTION 10 | ADD MATERNITY

If your product is not listed, adding maternity is not an option.

- BlueCare PPO\*  HSA Blue PPO\*  
 BlueCare PPO Plus\*  HSA Blue PPO Plus\*  
 Blue Choice\*\*  
 Blue Select\*  
 \$2,000  \$3,000  \$5,000  
 Blue Solution PPO\*  
 Comprehensive Blue PPO\*\*  
 Comprehensive Blue PPO II\*\*

\*Must be prior to conception – cannot be pregnant prior to the effective date of maternity coverage.

\*\*These plans have a 12-month waiting period before the maternity benefits will be covered.

## SECTION 11 | BENEFIT CHANGES

- Section 11 reflects benefit options available for **all** 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.
- Note:** Only decreases to policy limits are allowed in the sections below. To increase policy limits, please fill out a new application.
- If you still have questions, call customer service at **1-800-238-8379**.

Sample Identification Card

True BLUE PPO	
Member Name: JOHN DOE	Member DOB: 01/01/1987
Member ID: XCK900000000	Group # 000000-1
Dependents	RxBIN: 004336
02 BILL 02/01/2012	RxPCN: ADV
03 JACK 03/01/2015	RxGRP: RX3850
04 JILL 07/01/1995	PCP CoPay: \$30
	Rx: Value Formulary
	COMPREHENSIVE BLUE PPO III
	PPO

### ► ACCESSBLUE PPO

Your Group # on your ID card will be one of these:

**300101-300104** (non-grandfathered)

**700101-700104** (grandfathered)

Decrease my calendar-year deductible to:  \$500  \$1,000  \$2,500

**SECTION 11 | BENEFIT CHANGES (continued)****▶ BASIC BLUE PPO**

Your Group # on your ID card will be one of these:

**710000** (grandfathered)

Add benefit:

 Physician Office Visits Rider Prescription Drugs Rider**▶ BLUECARE PPO or BLUECARE PPO PLUS**

Your Group # on your ID card will be one of these:

**600010-600016** (grandfathered)**600030-600036** (grandfathered)Decrease my calendar-year deductible to:  \$500  \$1,000  \$1,500Decrease my calendar-year coinsurance maximum to:  \$1,000  \$2,000**▶ BLUE CHOICE**

Your Group # on your ID card will be one of these:

**771000-771123** (grandfathered)

Decrease my calendar-year deductible and benefit to:

**\$500 Deductible Options** \$1,000 out-of-pocket coinsurance maximum \$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.

**▶ BLUE SELECT**

Your Group # on your ID card will be one of these:

**601000-601007** (grandfathered)Decrease my calendar-year deductible to:  \$500  \$1,000  \$1,500Decrease my calendar-year coinsurance maximum to:  \$1,000**▶ BLUE SOLUTION PPO**

Your Group # on your ID card will be one of these:

**780000-780003** (grandfathered)Decrease my calendar-year deductible to:  \$750  \$1,500  \$3,000**▶ COMPREHENSIVE BLUE PPO or COMPREHENSIVE BLUE PPO II**

Your Group # on your ID card will be one of these:

**390000 – 390007 or 391000 – 398000** (non-grandfathered)**790000 – 790007 or 791000 – 798000** (grandfathered)Decrease my calendar-year deductible to:  \$500  \$1,000  \$2,500  \$5,000  \$10,000 \$15,000  \$20,000**▶ COMPREHENSIVE BLUE PPO III**

Your Group # on your ID card will be one of these:

**790008-790016** (non-grandfathered)Decrease my calendar-year deductible to:  \$1,000  \$1,500  \$2,500  \$5,000 \$7,500  \$10,000  \$15,000  \$20,000**▶ HSA BLUE PPO or HSA BLUE PPO PLUS**

Your Group # on your ID card will be one of these:

**730001-730015** (grandfathered)**750001-750015** (grandfathered)

Decrease my calendar-year deductible to:

 \$3,550 Individual/\$7,100 Family Deductible, 80/20% Coinsurance, \$10,000 Individual/\$20,000 Family Coinsurance Maximum \$3,550 Individual/\$7,100 Family Deductible, 80/20% Coinsurance, \$10,000 Individual/\$20,000 Family Coinsurance Maximum \$6,750 Individual/\$13,800 Family Deductible, 0% Coinsurance, No Calendar-Year Coinsurance Maximum

**SECTION 11 | BENEFIT CHANGES (continued)**

► **HSA BLUE PPO II**

Your Group # on your ID card will be one of these:

**311001-311005** (non-grandfathered)

**711001-711005** (grandfathered)

Decrease my calendar-year deductible to:  \$1,500 Individual/\$3,000 Family Deductible  
 \$2,500 Individual/\$5,000 Family Deductible

**SECTION 12 | DRIVER'S LICENSE INFORMATION [applicant(s) age 14 and older]**

Name: \_\_\_\_\_ License No. : \_\_\_\_\_ State: \_\_\_\_\_

Name: \_\_\_\_\_ License No. : \_\_\_\_\_ State: \_\_\_\_\_

Name: \_\_\_\_\_ License No. : \_\_\_\_\_ State: \_\_\_\_\_

In the past 5 years, has any applicant:

- Yes  No a. Had his or her driver's license suspended or revoked?  
 Yes  No b. Had two or more moving traffic violations?  
 Yes  No c. Been convicted or charged with driving under the influence of alcohol or a controlled substance?  
If you answered "yes," to any of the above questions, you MUST provide the following information:

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Violation(s): \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Violation(s): \_\_\_\_\_

**SECTION 13 | SPORTING OR HOBBY INFORMATION**

Yes  No Does any applicant intend to pilot a private aircraft; race a motor vehicle, boat or snowmobile; or participate in sky or scuba diving, ballooning, mountain climbing, hang gliding or any other hazardous sport, hobby or activity?

Name: \_\_\_\_\_ Please explain: \_\_\_\_\_

Name: \_\_\_\_\_ Please explain: \_\_\_\_\_

**SECTION 14 | TRAVEL OUTSIDE THE USA**

Yes  No Is any applicant planning to travel or work outside the USA within the next two years?  
If "yes," please provide the following:

Name (list all that apply): \_\_\_\_\_

Country: \_\_\_\_\_ Expected Length of Stay: \_\_\_\_\_ Departure date: \_\_\_\_\_ Return date: \_\_\_\_\_

Reason for Travel: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SECTION 15 | EXPECTANT/ADOPTIVE PARENT INFORMATION**

Yes  No Is any **male** applying for coverage an expectant father or a potential adoptive father?

Yes  No Is any **female** applying for coverage pregnant or a potential adoptive mother?

If "yes," please provide the following: Name: \_\_\_\_\_ Expected Delivery/Adoption Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**SECTION 16 | INFERTILITY**

Has any applicant or spouse of an applicant (**whether applying for coverage or not**):

Yes  No a. Ever been diagnosed or treated for infertility?

Yes  No b. Had surgical sterilization? If "yes," please provide the following:

Name: \_\_\_\_\_ Treatment/Procedure: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ Treatment/Procedure: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**SECTION 17 | TOBACCO USAGE**

Yes  No Has any applicant to be covered used any form of tobacco within the last 12 months? If "yes," please provide the following:  
 Name: \_\_\_\_\_ Type/Amount: \_\_\_\_\_ Date Last Used: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Name: \_\_\_\_\_ Type/Amount: \_\_\_\_\_ Date Last Used: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Name: \_\_\_\_\_ Type/Amount: \_\_\_\_\_ Date Last Used: \_\_\_\_/\_\_\_\_/\_\_\_\_

**SECTION 18 | PREVIOUS INSURANCE EXPERIENCE**

Yes  No Has any applicant ever been declined, rated, restricted or modified for the issuance of life, accident, health or long-term care insurance? If "yes," please provide the following:  
 Name: \_\_\_\_\_ Carrier Name: \_\_\_\_\_ Year: \_\_\_\_\_ Details: \_\_\_\_\_  
 Name: \_\_\_\_\_ Carrier Name: \_\_\_\_\_ Year: \_\_\_\_\_ Details: \_\_\_\_\_

**SECTION 19 | PRESCRIPTION QUESTIONNAIRE**

Yes  No Is any applicant **currently** taking any prescription medication, or has any applicant taken prescription medication in the **last 3 years?**

If you answered "yes," please provide full details below. Use separate sheet if necessary. **Any attachment must include all of the same information requested here and must be signed and dated.** A printout from the pharmacy is not acceptable.

**Please provide the name that would have been used at the time of the prescription (e.g., a maiden name may have been used).**

Person Treated	Name of Drug	Dosage	Specific Disorder or Illness	Start Date/ Stop Date	Degree of Recovery			Complete Name and Address of Prescribing Physician
					None	Partial	Full	
				____/____ mo year				
				____/____ mo year				
				____/____ mo year				
				____/____ mo year				
				____/____ mo year				
				____/____ mo year				
				____/____ mo year				

**SECTION 20 | MEDICAL QUESTIONNAIRE**

**ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.**

For each question checked below, give full details in the **ADDITIONAL MEDICAL INFORMATION** section which follows.

1. Has any applicant **ever** had or been told he/she had: **(Each section must have at least one box checked. When multiple medical conditions are listed, please CHECK all conditions that apply.)**

<p><b>A. BRAIN OR NERVOUS SYSTEM DISORDERS</b></p> <p><input type="checkbox"/> Alzheimer's disease or senile dementia</p> <p><input type="checkbox"/> Amyotrophic lateral sclerosis (Lou Gehrig's disease)</p> <p><input type="checkbox"/> Cerebral palsy</p> <p><input type="checkbox"/> Concussion or brain injury</p> <p><input type="checkbox"/> Convulsions, epilepsy or seizures</p> <p><input type="checkbox"/> Headaches or migraines</p> <p><input type="checkbox"/> Meningitis</p> <p><input type="checkbox"/> Multiple sclerosis, muscular dystrophy or myasthenia gravis</p> <p><input type="checkbox"/> Neuritis</p> <p><input type="checkbox"/> Paralysis or palsy</p> <p><input type="checkbox"/> Parkinson's disease</p> <p><input type="checkbox"/> Polyneuritis</p> <p><input type="checkbox"/> Vertigo, fainting or dizziness</p> <p><input type="checkbox"/> Any other disorder of the brain or nervous system</p> <p><input type="checkbox"/> <b>None of the above apply to any applicant(s)</b></p>	<p><b>D. KIDNEY, URINARY, REPRODUCTIVE</b></p> <p><input type="checkbox"/> Abnormal pap smear</p> <p><input type="checkbox"/> Bladder or renal stones</p> <p><input type="checkbox"/> Cesarean section or miscarriage</p> <p><input type="checkbox"/> Dialysis</p> <p><input type="checkbox"/> Nephritis</p> <p><input type="checkbox"/> Nephrotic syndrome, renal disease or failure</p> <p><input type="checkbox"/> Sexually transmitted disease</p> <p><input type="checkbox"/> Sugar, blood or protein in urine</p> <p><input type="checkbox"/> Any other disorder of the kidneys or urinary tract</p> <p><input type="checkbox"/> Any other disorder of the male reproductive organs, including prostate</p> <p><input type="checkbox"/> Any other disorder of the female reproductive organs, including ovaries or breasts</p> <p><input type="checkbox"/> <b>None of the above apply to any applicant(s)</b></p>	<p><b>MUSCULOSKELETAL (continued)</b></p> <p><input type="checkbox"/> Lupus, systemic</p> <p><input type="checkbox"/> Temporomandibular joint disorder (TMJ/TMD) or craniomandibular disorder</p> <p><input type="checkbox"/> Any other disorder of the muscles, bones or joints to include chiropractic care</p> <p><input type="checkbox"/> <b>None of the above apply to any applicant(s)</b></p>
<p><b>B. CIRCULATORY</b></p> <p><input type="checkbox"/> Abnormal cholesterol/lipids</p> <p><input type="checkbox"/> Angina, heart attack, myocardial infarction</p> <p><input type="checkbox"/> Arteriosclerosis, atherosclerosis, coronary artery disease, stent placement or angioplasty</p> <p><input type="checkbox"/> Cerebrovascular accident (stroke), including transient ischemic attack (TIA)</p> <p><input type="checkbox"/> Chest pain, shortness of breath, heart murmur, palpitation of the heart, ablation and rheumatic fever</p> <p><input type="checkbox"/> Heart bypass surgery/pacemaker implant</p> <p><input type="checkbox"/> Heart or vein/artery surgery</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Hemophilia</p> <p><input type="checkbox"/> Valve repair/replacement</p> <p><input type="checkbox"/> Any other disorder of the heart, blood, blood vessels or circulatory system</p> <p><input type="checkbox"/> <b>None of the above apply to any applicant(s)</b></p>	<p><b>E. RESPIRATORY</b></p> <p><input type="checkbox"/> Allergies, asthma or bronchitis</p> <p><input type="checkbox"/> Chronic pulmonary disease, emphysema, lung disease or respiratory syncytial virus (RSV)</p> <p><input type="checkbox"/> Obstructive or reactive airway disorder</p> <p><input type="checkbox"/> Sleep apnea, cpap, bipap or vpap</p> <p><input type="checkbox"/> Any other disorder of the lungs, bronchial tubes or respiratory system</p> <p><input type="checkbox"/> <b>None of the above apply to any applicant(s)</b></p>	<p><b>I. EARS/EYES/NOSE/THROAT</b></p> <p><input type="checkbox"/> Cataracts or glaucoma</p> <p><input type="checkbox"/> Meniere's disease</p> <p><input type="checkbox"/> Nasal septal defect</p> <p><input type="checkbox"/> Sinusitis, tonsillitis or otitis media</p> <p><input type="checkbox"/> Any other disorder of the eyes, ears, nose, throat or esophagus</p> <p><input type="checkbox"/> <b>None of the above apply to any applicant(s)</b></p>
<p><b>C. DIGESTIVE</b></p> <p><input type="checkbox"/> Cirrhosis</p> <p><input type="checkbox"/> Crohn's disease or ulcerative colitis</p> <p><input type="checkbox"/> Gastric bypass surgery or other weight loss procedure</p> <p><input type="checkbox"/> Gastric or duodenal ulcer</p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> Hernia/hemorrhoids</p> <p><input type="checkbox"/> Irritable bowel syndrome or gastric esophageal reflux disorder (GERD)</p> <p><input type="checkbox"/> Pancreatitis</p> <p><input type="checkbox"/> Pyloric stenosis</p> <p><input type="checkbox"/> Any other disorder of stomach, intestines, liver, gallbladder or rectum</p> <p><input type="checkbox"/> <b>None of the above apply to any applicant(s)</b></p>	<p><b>F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS</b></p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Cancer, leukemia or malignancy of any kind</p> <p><input type="checkbox"/> Hodgkin's or Non-Hodgkin's disease</p> <p><input type="checkbox"/> Melanoma, neoplasm or tumor</p> <p><input type="checkbox"/> Any other disorder of the lymphatic system</p> <p><input type="checkbox"/> Any disorder of the skin</p> <p><input type="checkbox"/> <b>None of the above apply to any applicant(s)</b></p>	<p><b>J. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE</b></p> <p><input type="checkbox"/> Anxiety, insomnia, sleep disorder, depression, emotional problems or nervous disorder</p> <p><input type="checkbox"/> Attempted suicide</p> <p><input type="checkbox"/> Counseling or psychiatric treatment (in-patient or out-patient)</p> <p><input type="checkbox"/> Bipolar disorder, obsessive compulsive disorder or developmental disorder</p> <p><input type="checkbox"/> Eating disorder</p> <p><input type="checkbox"/> Any other mental, emotional disorder or situation, including ADD/ADHD</p> <p><input type="checkbox"/> <b>None of the above apply to any applicant(s)</b></p>
	<p><b>G. GLANDULAR DISORDERS</b></p> <p><input type="checkbox"/> Adrenal disorders</p> <p><input type="checkbox"/> Diabetes, abnormal glucose</p> <p><input type="checkbox"/> Goiter or thyroid disease</p> <p><input type="checkbox"/> Any disorder of the pancreas</p> <p><input type="checkbox"/> <b>None of the above apply to any applicant(s)</b></p>	<p><b>K. OTHER</b></p> <p><input type="checkbox"/> Current patient in a hospital or nursing home</p> <p><input type="checkbox"/> Pending Surgery Surgery Date: __/__/__</p> <p><input type="checkbox"/> Sarcoidosis</p> <p><input type="checkbox"/> Breast implants</p> <p><input type="checkbox"/> Saline <input type="checkbox"/> Silicone Surgery Date: __/__/__</p> <p><input type="checkbox"/> Any other implant(s), prosthetic device(s), internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents)</p> <p><input type="checkbox"/> Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder or HIV</p> <p><input type="checkbox"/> Transplant recipient</p> <p><input type="checkbox"/> Any injury, deformity, incapacitation, disease or condition not listed elsewhere</p> <p><input type="checkbox"/> <b>None of the above apply to any applicant(s)</b></p>
	<p><b>H. MUSCULOSKELETAL</b></p> <p><input type="checkbox"/> Arthritis, osteoarthritis, degenerative joint or disc disease</p> <p><input type="checkbox"/> Back pain and/or neck pain</p> <p><input type="checkbox"/> Chronic fatigue</p> <p><input type="checkbox"/> Connective tissue disorder</p> <p><input type="checkbox"/> Disease or disorder of the joints: knee(s), shoulder(s), elbow(s), wrist(s), other</p> <p><input type="checkbox"/> Fibromyalgia, bursitis or tendonitis</p> <p><input type="checkbox"/> Fracture(s) or broken bone(s)</p> <p>Exposed bone <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Gout</p> <p><b>(Continued on the next column)</b></p>	



**SECTION 20 | MEDICAL QUESTIONNAIRE (continued)**

2. Has any applicant ever:

- Yes  No a. Consumed alcohol to excess, received treatment, or joined an organization for alcoholism or drug addictions?
- Yes  No b. Used any addictive or non-addictive drug or substance for purposes other than recommended by your physician?
- Yes  No c. Been treated for, diagnosed by or consulted a physician, psychotherapist, counselor or any other provider, or had any indication(s) of having a drug dependency/habit?
- Yes  No d. Required the assistance of any other individual for performances of any activities of daily living? If "Yes," please explain: \_\_\_\_\_
- Yes  No e. Been told that he/she has or has had hearing problems, ear disorder(s) or has need of hearing devices due to any kind of hearing or ear impairment, or does any applicant have an existing hearing aid device in place?

**ADDITIONAL MEDICAL INFORMATION**

Give full details to questions answered affirmatively (checked or answered "Yes") to explain answers to questions in SECTION 20. In addition to **condition/illness** please provide the **type of treatment** provided or planned – for example, surgery, X-rays, EKG, lab tests, hospitalization, emergency room visit, nursing home confinement, doctor visits, rehabilitation services, occupational therapy, physical therapy, speech therapy or chiropractic treatments. Please ensure you include **all** the treatments that apply. **Please use the name that would have been given at the time of the physician visit – e.g., a maiden name.**

Question Number(s)	Person Treated	Specific Disorder/Illness and Type of Treatment	Date of First Visit ____/____/____ mo year	Date of Last Visit ____/____/____ mo year	Total # of Visits	Degree of Recovery			Complete Name and Address of Physician
						None	Partial	Full	
			____/____/____ mo year	____/____/____ mo year					
			____/____/____ mo year	____/____/____ mo year					
			____/____/____ mo year	____/____/____ mo year					
			____/____/____ mo year	____/____/____ mo year					
			____/____/____ mo year	____/____/____ mo year					

**SECTION 21 | PHYSICIAN INFORMATION (Please provide for each applicant for the last five years)**

Applicant's Name	Complete Name and Address of Physician	Date of Last Visit*	Reason for Visit	Treatment/ Results

\*Please write **NO VISIT** in this box if the applicant has never seen the physician.

**PLEASE READ BEFORE SIGNING**

I understand: (1) This application may be rejected if the applicant is age 19 or older. (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) 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. (4) 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. (5) 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.

**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.**

**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 19 or older) <b>OR</b> Parent Legal/Guardian (if policy for a minor)	(Please Print) <b>X</b>	Date Signed
	(Please Sign) <b>X</b>	
Spouse (required if applying)	(Please Sign) <b>X</b>	Date Signed
Dependent age 18 or older (required if applying)	(Please Sign) <b>X</b>	Date Signed

**CUSTODIAL PARENT SECTION**

If any applicant under age 19 (primary applicant or dependent), named on this application, does NOT reside with the policyholder indicated in Section 1, the **custodial parent's** signature is also required.

Custodial Parent's Name (please print)	<b>X</b>	Telephone No.
Custodial Parent's Address	Street or PO Box	City State Zip
Custodial Parent's Signature	<b>X</b>	Date Signed

**IMPORTANT: Please be sure to also sign and return Page 10 of this document. We cannot process your application without the signed Authorization to Disclose Protected Health Information form.**

# THE FORM BELOW MUST BE COMPLETED IN ORDER TO PROCESS THE APPLICATION

## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, pharmacy benefits manager, or other provider of healthcare services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any healthcare item or service in relation to the healthcare provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices. I understand that information re-disclosed may no longer be protected by federal privacy regulations. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, PO Box 2181, Little Rock, AR 72203-2181. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 et seq., the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 et seq. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 et seq. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

This authorization includes authorization to release information on the diagnosis and treatment of mental illness, alcohol, and drug use, as well as authorization to release information on the diagnosis, treatment, and testing results related to HIV-AIDS, and sexually transmitted diseases, unless otherwise restricted by applicable law.

<b>Applicants age 18 and older</b>	This authorization must be signed by <b>each applicant age 18 or older.</b>		
	Print Name(s)	Signature	Date
			/ /
			/ /
			/ /
			/ /
<b>Applicants under age 18</b>	List applicants under age 18 (Print Name).		
			/ /
Parent/Legal Guardian's Signature (if policy for a minor)		Date	

Detach and keep for your records

### 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



## **\*\*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](http://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.



Arkansas  
**BlueCross BlueShield**

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