



Arkansas
BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

Individual/Family Health Insurance **CHANGE FORM** Gold, Silver, Bronze and Catastrophic Plans

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 policy** ➔ Complete sections 1, 2, 4 and 6
 - **Add person to policy** ➔ Complete sections 1, 2, 4, 7, 8, 9 and 10
 - **Make someone else the primary policyholder** ➔ Complete sections 1, 2, 4, 7, 8, 9, 10 and 11
 - **Split my policy into two or more policies** ➔ Complete sections 1, 2, 4, 7, 8, 9, 10 and 12



INSTRUCTIONS

Changes to your policy 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 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.

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 Arkansas Blue Cross at **501-378-3752** or emailed to **crmcustomerservice@arkbluecross.com** immediately following the submission of the application.



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

SECTION 1 | CURRENT POLICYHOLDER INFORMATION

Member ID: _____ Group Number: _____ Date of Birth: ____/____/____
First Name: _____ M.I.: _____ Last Name: _____

SECTION 2 | CONTACT INFORMATION

Table with 4 columns: Primary Phone Number, Alternate Phone Number, E-mail Address, and 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.

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 | POLICY CHANGE ELIGIBILITY

Qualifying life event changes allow you to make changes to your policy 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)
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 policy and - if applicable - provide date of qualifying life event.

Table with 4 columns: Description, Date, Description, Date. Contains 16 checkboxes for various qualifying life events.

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 45 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 POLICY

In the event you would like to **terminate coverage** for a covered person, including the policyholder, 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 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 12 – Split Policy**. A signature is **required** by **both** the current policyholder and new policyholder. **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 | ADDING 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)
- 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: _____

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 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 11 | OWNERSHIP CHANGE

If both the policyholder and spouse are retaining coverage, but you would like to change the ownership of the policy from the current policyholder to the spouse, complete this section. **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 12 | 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 Number ()	Alternate Phone Number ()	E-mail Address
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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 _____

SECTION 13 | POLICYHOLDER PROXY AND MEMBER INFORMATION

As a Policyholder, you are a member of Arkansas Blue Cross and Blue Shield. By accepting this Policy you appoint the Board of Directors ("Board") of the Company to act on your behalf at all meetings of Members of the Company. This appointment shall include such persons as the Board may designate by resolution to act on its behalf. This proxy gives the Board, or its designee, full power to vote for you on all matters that may be voted upon at any meeting. The annual meeting of Members is held each year at the home office of Arkansas Blue Cross and Blue Shield located at 601 S. Gaines Street, Little Rock, Arkansas, on the third Monday of March, at 1:00 p.m. If the third Monday of March is a legal holiday, then the meeting will be at the same time and place on the next day after, which is not a legal holiday. A special meeting may be called upon notice mailed not less than ten (10) or more than sixty (60) days prior to such meeting. This proxy, unless revoked, shall remain in effect during the term of this Policy. You may revoke this proxy in writing by advising the Company of such revocation at least five (5) days prior to any meeting. You may also revoke its proxy by attending and voting in person at any Members' meeting.

PLEASE READ BEFORE SIGNING

I UNDERSTAND: (1) The agent or broker involved in this insurance transaction may receive compensation from Arkansas Blue Cross and Blue Shield (hereafter referred to as the COMPANY), or one of its affiliates, for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. 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) The COMPANY 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, the COMPANY may take legal action at any time; (c) understand my signature authorizes the COMPANY to coordinate benefits under this policy 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 policy 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 Arkansas Blue Cross and Blue Shield or your agent if you wish to purchase pediatric dental coverage or a stand-alone services product.

Arkansas Blue Cross and Blue Shield 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)

		OFFICE USE ONLY
Current Policyholder OR Parent Legal/Guardian (if policy for a minor)	(Please Print) X _____ Date	
	(Please Sign) X _____ Date	
New Policyholder X _____ Date		

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

NON-DISCRIMINATION AND LANGUAGE ASSISTANCE NOTICE

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.

We provide free aids and services 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, contact our Civil Rights Coordinator.**

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator

601 Gaines Street, Little Rock, AR 72201
Phone: 1-844-662-2276; TDD: 1-844-662-2275

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>.

ATTENTION: Language assistance services, free of charge, are available to you. Call 1- 844-662-2276.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-662-2276 .

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-662-2276。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-662-2276

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-662-2276 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-662-2276.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-662-2276.

ملاحظة: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية مجاناً. دعوة 1-844-662-2276 العدد.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-662-2276.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-662-2276.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-662-2276.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-662-2276.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-662-2276.

注意事項 : 日本語を話される場合、無料の言語支援をご利用いただけます。1-844-662-2276まで、お電話にてご連絡ください。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-662-2276.

ملاحظة: إذا كنت تتحدث باللغة الفارسية، والخدمات اللغوية المقدمة مجاناً بالنسبة لك. يرجى الاتصال 1-844-662-2276

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-662-2276.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-662-2276 पर कॉल करें।

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-662-2276.

انتباه: آپ اردو بولتے ہیں تو، زبان کی مدد کی خدمات بلا معاوضہ دستیاب مفت ہیں۔ کال کریں 1-844-662-2276

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທສ 1-844-662-2276.

LALE: Ñe kwōj kōnono Kajin Majōl, kwomarōñ bōk jermal in jipañ ilo kajin ñe aṃ ejjeļok wōñāñ. Kaalok 1-844-662-2276