

SERFF Tracking Number: ARBB-127376475 State: Arkansas  
 Filing Company: Arkansas Blue Cross and Blue Shield State Tracking Number: 49591  
 Company Tracking Number: 10-77CRF R08/11  
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO  
 Product Name: Application  
 Project Name/Number: Change Request Form/10-77CRF R08/11

## Filing at a Glance

Company: Arkansas Blue Cross and Blue Shield

Product Name: Application

SERFF Tr Num: ARBB-127376475 State: Arkansas

TOI: H16G Group Health - Major Medical

SERFF Status: Closed-Approved-  
Closed State Tr Num: 49591

Sub-TOI: H16G.001A Any Size Group - PPO

Co Tr Num: 10-77CRF R08/11

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Christi Kittler, Yvonne  
McNaughton, Frank Sewall, Rita  
Thatcher, Evelyn Laney

Disposition Date: 08/19/2011

Date Submitted: 08/18/2011

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Change Request Form

Status of Filing in Domicile:

Project Number: 10-77CRF R08/11

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Arkansas is state  
of domicile.

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer

Overall Rate Impact:

Filing Status Changed: 08/19/2011

State Status Changed: 08/19/2011

Deemer Date:

Created By: Evelyn Laney

Submitted By: Evelyn Laney

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

Attached please find Change Request Form (Form No. 10-77CRF R08/11) for your review and approval if indicated. This form was revised to add the questions "Has the Employee being terminated contributed to the premium past the termination date requested?" "Has the Member being terminated contributed to the premium past the termination date requested?"

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I certify that the submission meets the provisions of Arkansas Insurance Department Rule & Regulation 19. I further certify that the Life and Health Guaranty Association Notices required by Arkansas Insurance Department Rule & Regulation 49 and the consumer information notice required by Arkansas Code Annotated §23-79-138 are incorporated in the policies to which these amendments are attached.

Please feel free to contact me at 378-2165 with any questions you may have.

## Company and Contact

### Filing Contact Information

Evelyn Laney, Senior Compliance Analyst exlaney@arkbluecross.com  
 320 West Capitol, Ste 211 501-378-2165 [Phone]  
 Little Rock, AR 72201 501-378-2975 [FAX]

### Filing Company Information

Arkansas Blue Cross and Blue Shield	CoCode: 83470	State of Domicile: Arkansas
601 S. Gaines Street	Group Code:	Company Type:
Little Rock, AR 72201	Group Name:	State ID Number: N/A
(501) 378-2967 ext. [Phone]	FEIN Number: 71-0226428	

## Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	\$50.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Arkansas Blue Cross and Blue Shield	\$50.00	08/18/2011	50742129

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/19/2011	08/19/2011

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## **Disposition**

Disposition Date: 08/19/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	PPACA Uniform Compliance Summary	Approved-Closed	Yes
<b>Form</b>	Application	Approved-Closed	Yes

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## Form Schedule

**Lead Form Number: 10-77CRF R08/11**

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 08/19/2011	10-77CRF R08/11	Application/ Application Enrollment Form	Initial			10-77CRF R08- 11ChangeRe quest Form.pdf



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

Arkansas Blue Cross and Blue Shield  
ATTN: Customer Accounts 2 North  
P O Box 2181  
Little Rock, AR 72203-9974  
Fax 501-378-3248  
E-Mail: [Groupaccounts@arkbluecross.com](mailto:Groupaccounts@arkbluecross.com)

**ID #**

**Group Name:**

**Group #:**



**Health Advantage**  
An Independent Licensee of the Blue Cross and Blue Shield Association

Health Advantage  
ATTN: Customer Accounts  
P O Box 8069  
Little Rock, AR 72203-8069  
Fax 501-301-6869  
E-Mail: [HAcustacct@arkbluecross.com](mailto:HAcustacct@arkbluecross.com)

**CHANGE REQUEST FORM**

First Name	M.I.	Last Name	Social Security No.	Date of Birth / /
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Home Address <input type="checkbox"/> <i>Check if Changed</i>	Phone # <input type="checkbox"/> <i>Check if Changed</i>
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**Change coverage as indicated below:**

Name Change: Current Name : \_\_\_\_\_ New Name : \_\_\_\_\_

Cancel Employee:  Left Job  Other: Reason \_\_\_\_\_ Cancel Coverage \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Has the Employee being terminated contributed to the premium past the termination date requested?  Yes  No

Cancel coverage for a Family Member : \_\_\_\_\_ Last Month employee contributed premium: \_\_\_\_\_

1. Member Name: _____	Termination Date: ____ / ____ / ____	Last Month employee contributed premium: _____
2. Member Name: _____	Termination Date: ____ / ____ / ____	Last Month employee contributed premium: _____

Has the Member being terminated contributed to the premium past the termination date requested?  Yes  No

US Able Life Insurance – Beneficiary Change

US Able Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield and Health Advantage. US Able Life does not sell or service Arkansas Blue Cross and Blue Shield or Health Advantage products. US Able Life is solely responsible for life insurance.

I hereby designate the beneficiary or beneficiaries listed below under this certificate and revoke the appointment of any existing beneficiary.

First Name	MI	Last Name	Date of Birth	Relationship
			/ /	

**The following changes apply to Health Advantage contracts only:**

Select or Change Primary Care Physician (PCP)

Member Name: \_\_\_\_\_ PCP Name: \_\_\_\_\_ PCP # : \_\_\_\_\_

Clinic Name \_\_\_\_\_ Clinic Address: \_\_\_\_\_

In signing below, I represent that the statements and answers given in this application are true, complete and correctly recorded. I understand that any performance of any act or practice constituting fraud or intentional misrepresentation of material fact may result in cancellation of any coverage issued in reliance thereon, and that Arkansas Blue Cross and Blue Shield, Health Advantage, and/or US Able Life may recover monies and damages incidental and consequential to that result.

**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.**

Employee Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Group Administrator Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Flesch Certification	Approved-Closed	08/19/2011
<b>Bypass Reason:</b>	Not required.		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Application	Approved-Closed	08/19/2011
<b>Comments:</b>	See attached.		
<b>Attachment:</b>	10-77CRF R08-11ChangeRequest Form.pdf		

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	PPACA Uniform Compliance Summary	Approved-Closed	08/19/2011
<b>Bypass Reason:</b>	Not PPACA related.		
<b>Comments:</b>			



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