

SERFF Tracking Number: ARBB-128378859 State: Arkansas  
Filing Company: Arkansas Blue Cross and Blue Shield State Tracking Number:  
Company Tracking Number: U-65 APP AG R07-12  
TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider  
(PPO)  
Product Name: Applications  
Project Name/Number: Under 65 Applications/U-65 APP AG, U-65 APP DR, U-65 APP LB AG

## Filing at a Glance

Company: Arkansas Blue Cross and Blue Shield

Product Name: Applications

TOI: H16I Individual Health - Major Medical

Sub-TOI: H16I.005A Individual - Preferred  
Provider (PPO)

Filing Type: Form

SERFF Tr Num: ARBB-128378859 State: Arkansas

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

Co Tr Num: U-65 APP AG R07-12 State Status: Approved-Closed

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

Date Submitted: 05/18/2012

Reviewer(s): Rosalind Minor

Disposition Date: 05/21/2012

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

State Filing Description:

Implementation Date:

## General Information

Project Name: Under 65 Applications

Project Number: U-65 APP AG, U-65 APP DR, U-65 APP LB AG

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Evelyn Laney

PPACA: Not PPACA-Related

PPACA Notes: null

Healthcare.gov ID:

Filing Description:

Attached please find forms U-65 APP AG,U-65 APP DR, U-65 APP LB AG, U-65 APP LB DR,U-65 CF NonUnd,  
UndChg Form, U-65 CF NewAdopt R07/12 for your review and approval if indicated.

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Arkansas is state  
of domicile.

Market Type: Individual

Individual Market Type: Individual

Filing Status Changed: 05/21/2012

State Status Changed: 05/21/2012

Created By: Evelyn Laney

Corresponding Filing Tracking Number:

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Please see the following explanation of all of the changes made on the applications.

#### Under 65 App – Agent and Direct Response

- Updated Form IDs.
- Modified the form to address the applicants as a “primary applicant” instead of “proposed insured”. (Including on the signature page).
- On the instruction sheet, modified the instruction on Applicants residing in the U.S. to include the stipulation that the applicant must have had a primary care physician in the U.S. for one year prior to applying.
- Updated Authorization address to PO Box 2181, Little Rock, AR 72203.
- Removed the “Best Time to Call” field.
- Modified the household information section to include the following questions:
  - o Do all applicants under the age of 19 reside in the same household?
  - o Are all applicants permanent, legal residents of Arkansas?
- Modified the current/previous insurance information section to ask the following:
  - o Have any applicants recently lost employer-sponsored health coverage?
  - o Have any applicants recently “involuntarily” lost other health coverage?
  - o Are any applicants covered by Medicaid (including AR Kids First)?
- Removed Term Life and Critical Illness options.
- Removed the word “proposed” from in front of “applicant” in section 21 and 24.
- Modified the “Please Read Before Signing” section with the following, updated sentences:
  - o As the result of the assessment, if I am age 19 or older, my application may be approved with no changes, approved but charged a higher premium, and/or approved with non-medical exclusions, or I may be declined for coverage.
  - o (5) The Health insurance applied for will not be effective on any proposed insured if there has been a change in the health of any proposed insured between the date this application is signed and the effective date of coverage.
- Added custodial parent address fields on the signature page.
- Added an “Office Use Only” box for printing a label to include the contract number and policy holder’s name.
- Added a “Reminders” page.

#### Under 65 List Bill App – Agent and Direct Response

- Updated Form IDs.
- Modified the form to address the applicants as a “primary applicant” instead of “proposed insured”. (Including on the signature page).
- On the instruction sheet, modified the instruction on Applicants residing in the U.S. to include the stipulation that the applicant must have had a primary care physician in the U.S. for one year prior to applying.
- Updated Authorization address to PO Box 2181, Little Rock, AR 72203.
- Removed the “Best Time to Call” field.
- Modified the household information section to include the following questions:

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Product Name: Applications

Project Name/Number: Under 65 Applications/U-65 APP AG, U-65 APP DR, U-65 APP LB AG

- o Do all applicants under the age of 19 reside in the same household?
- o Are all applicants permanent, legal residents of Arkansas?
- Modified the current/previous insurance information section to ask the following:
- o Have any applicants recently lost employer-sponsored health coverage?
- o Have any applicants recently “involuntarily” lost other health coverage?
- o Are any applicants covered by Medicaid (including AR Kids First)?
- Removed Term Life options.
- Removed the word “proposed” from in front of “applicant” in section 21 and 24.
- Modified the “Please Read Before Signing” section with the following, updated sentences:
  - o As the result of the assessment, if I am age 19 or older, my application may be approved with no changes, approved but charged a higher premium, and/or approved with non-medical exclusions, or I may be declined for coverage.
  - o (5) The Health insurance applied for will not be effective on any proposed insured if there has been a change in the health of any proposed insured between the date this application is signed and the effective date of coverage.
- Moved the following sentence to the top of the signature section:
  - o I certify that I signed this application in the state of Arkansas.
- Added custodial parent address fields on the signature page.
- Added an “Office Use Only” box for printing a label to include the contract number and policy holder's name.
- Added a “Reminders” page.

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#### Under 65 Newborn/Adopted Change Form

- Updated the Form IDs.
  - Updated Authorization address to PO Box 2181, Little Rock, AR 72203.
  - Removed the “Best Time to Call” field.
  - Moved the signature section to the back of the form.
  - Added an “Office Use Only” box for printing a label to include the contract number and policy holder's name.
  - Updated the cover page with the following sentence in the first paragraph:
    - o Documentation is required to add an adopted child(ren) and the appropriate documentation such as a copy of adoption papers or other court papers must accompany this form, in order to support this change. If you are requesting to add a newborn or adopted child outside the above-referenced time limits, you will need to complete an Underwriting Change Form.
  - Updated the fourth bullet in the instructions section:
    - o If you make a mistake, please mark through the incorrect information, initial it, date it and then provide the correct information.
- Updated the website at the bottom of the cover page to be [www.healthcare.gov](http://www.healthcare.gov).

#### Under 65 Non Underwriting Change Form

SERFF Tracking Number: ARBB-128378859 State: Arkansas  
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Product Name: Applications  
Project Name/Number: Under 65 Applications/U-65 APP AG, U-65 APP DR, U-65 APP LB AG

- Updated the Form IDs.
- Updated the website at the bottom of the cover page to be [www.healthcare.gov](http://www.healthcare.gov).
- Updated the instruction sheet to correspond with the sections in the form correctly.
- Removed the "Best Time to Call" field.
- Added date fields for all Policy Change Eligibility options and changed the wording to "Check all applicable boxes below that support your change request and provide date of qualifying life event."
- Added an "Office Use Only" box for printing a label to include the contract number and policy holder's name.

#### Under 65 Underwriting Change Form

- Updated the Form IDs.
- Updated the website at the bottom of the cover page to be [www.healthcare.gov](http://www.healthcare.gov).
- Added date fields for all Policy Change Eligibility options and changed the wording to "Check all applicable boxes below that support your change request and provide date of qualifying life event."
- Modified the household information section to include the following questions:
  - o Do all applicants under the age of 19 reside in the same household?
  - o Are all applicants permanent, legal residents of Arkansas?
- Modified the current/previous insurance information section to ask the following:
  - o Have any applicants recently lost employer-sponsored health coverage?
  - o Have any applicants recently "involuntarily" lost other health coverage?
  - o Are any applicants covered by Medicaid (including AR Kids First)?
- Modified the "Please Read before Signing" section with the following updated sentence:
  - o (4) Any members age 19 or older added to my policy will be subject to a 12-month pre-existing waiting period.
- Added custodial parent address fields on the signature page.

Added an "Office Use Only" box for printing a label to include the contract number and policy holder's name.

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

State Narrative:

## Company and Contact

### Filing Contact Information

Evelyn Laney, Senior Compliance Analyst [exlaney@arkbluecross.com](mailto: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:

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Product Name: Applications  
Project Name/Number: Under 65 Applications/U-65 APP AG, U-65 APP DR, U-65 APP LB AG  
Little Rock, AR 72201 Group Name: State ID Number: N/A  
(501) 378-2967 ext. [Phone] FEIN Number: 71-0226428  
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## Filing Fees

Fee Required? Yes  
Fee Amount: \$350.00  
Retaliatory? No  
Fee Explanation: \$50.00 per application  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Arkansas Blue Cross and Blue Shield	\$350.00	05/18/2012	59276082

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/21/2012	05/21/2012

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## Disposition

Disposition Date: 05/21/2012

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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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number: U-65 APP AG R07-12

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/21/2012	U-65 APP AG R07/12	Application/ Enrollment Form	Application/ Enrollment	Revised	Replaced Form #: U-65 APP AG R07/12 Previous Filing #: U-65 APP AG R01/12		U-65 APP AG (R07-12).pdf
Approved-Closed 05/21/2012	U-65 APP DR R07/12	Application/ Enrollment Form	Application/ Enrollment	Revised	Replaced Form #: U-65 APP DR R07/12 Previous Filing #: U-65 APP DR R01/12		U-65 APP DR (R07-12).pdf
Approved-Closed 05/21/2012	U-65 APP LB AG R07/12	Application/ Enrollment Form	Application/ Enrollment	Revised	Replaced Form #: U-65 APP LB AG R07/12 Previous Filing #: U-65 APP LB AG R01/12		U-65 APP LB AG (R07-12).pdf
Approved-Closed 05/21/2012	U-65 APP LB DR R07/12	Application/ Enrollment Form	Application/ Enrollment	Revised	Replaced Form #: U-65 APP LB DR R07/12 Previous Filing #: U-65 APP LB DR R01/12		U-65 APP LB DR (R07-12).pdf
Approved-Closed 05/21/2012	U-65 CF R07/12	Application/ Enrollment Form	Application/ Enrollment	Revised	Replaced Form #: U-65 CF NonUnd R07/12 Previous Filing #: U-65 CF NonUnd R01/12		U-65 CF NonUnd (R07-12).pdf
Approved-Closed	UndChg Form	Application/ Enrollment Form	Application/ Enrollment	Revised	Replaced Form #: UndChg Form		UndChg Form (R07-12).pdf

<i>SERFF Tracking Number:</i>	<i>ARBB-128378859</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Arkansas Blue Cross and Blue Shield</i>	<i>State Tracking Number:</i>	
<i>Company Tracking Number:</i>	<i>U-65 APP AG R07-12</i>		
<i>TOI:</i>	<i>H161 Individual Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H161.005A Individual - Preferred Provider (PPO)</i>
<i>Product Name:</i>	<i>Applications</i>		
<i>Project Name/Number:</i>	<i>Under 65 Applications/U-65 APP AG, U-65 APP DR, U-65 APP LB AG</i>		
<i>05/21/2012 R07/12</i>	<i>Form</i>	<i>R01/12</i>	
		<i>Previous Filing #:</i>	
		<i>UndChg Form</i>	
		<i>R01/12</i>	
<i>Approved- U-65 CF</i>	<i>Application/ Application</i>	<i>Revised</i>	<i>U-65 CF</i>
<i>Closed NewAdopt</i>	<i>Enrollment</i>	<i>Replaced Form #: U-</i>	<i>NewAdopt</i>
<i>05/21/2012 R07/12</i>	<i>Form</i>	<i>65 CF NewAdopt</i>	<i>(R07-12).pdf</i>
		<i>R07/12</i>	
		<i>Previous Filing #: U-</i>	
		<i>65 CF NewAdopt</i>	
		<i>R01/12</i>	



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# Individual/Family Health Insurance Application

**READ ALL INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION. APPLICATION MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.**

- This application 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 application must be completed in dark blue or black ink. Applications 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 application.
- Any **attachments** submitted with the application must be signed and dated.
- **Do not send any money with this application.**
- Please ensure all required parties have signed and dated the application prior to submission.
- **We strongly recommend you make a copy of this completed application for your records.**

## SECTION 1 – WHO IS APPLYING

- Oldest person applying for coverage should be listed on the first line of the application. If applicant is under the age of 19, parent or guardian information should be indicated in Section 2 (*Parent/Guardian*).
- Social Security numbers are **required** for every applicant. If you are applying for coverage for a child less than one year old who does not yet have a Social Security number, you may apply; however, you will be required to submit the Social Security number within 90 days.
- If applying for Individual and Spouse coverage, primary applicant must be age 19 or older and spouse must be age 14 or older.
- If applying for Individual, Spouse and Child(ren) coverage or Individual and Child(ren) coverage, primary applicant must be age 19 or older.
- In “*Relationship*” box, indicate “spouse, son, daughter, stepson, stepdaughter, or dependent child” beside each dependent’s name.
- If applying for coverage for dependent child other than son, daughter, stepson, or stepdaughter, submit copy of appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.
- If primary applicant is under age 19 and does NOT reside with the Parent/Guardian named on this application, custodial parent must also sign the application (see *Signature Section* on Page 7).
- If any dependents are under age 19 and do NOT reside with the primary applicant, the custodial parent must also sign the application (see *Signature Section* on Page 7).

## SECTION 2 – PARENT/GUARDIAN (If policy is only for a child under age 19)

- If applicant is under the age of 19, parent or guardian information must be indicated in this section.
- If applying for coverage as the “Guardian” of a dependent child under the age of 19, please submit appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.

## SECTION 4 – 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 must be submitted 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 will also be contacted by phone to complete a Foreign National Questionnaire.

## SECTION 12 – REQUESTED EFFECTIVE DATE

- The applicant should check preference for 1<sup>st</sup> or 15<sup>th</sup> of the month effective date. This is the applicant’s opportunity to request the effective date coordinates with the termination of current health insurance coverage. While we cannot guarantee a specific requested effective date, we will make every effort to accommodate the request. If the application is approved, the effective date will be assigned based on the date of approval. This means retroactive effective dates will not be assigned.

## SECTION 16 – TYPE OF COVERAGE

- If applicant is applying for coverage other than “Individual,” please indicate if still interested in coverage if one or more applicants is declined or ineligible. If “Yes” is selected, Arkansas Blue Cross will continue the underwriting process if one or more applicants is declined or ineligible. If “No” is selected, Arkansas Blue Cross will close out the application if one or more applicants is declined or ineligible.



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# IMPORTANT:

**We cannot process your application without this completed form.**

## 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 health care 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 health care item or service in relation to the health care 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).

<b>Applicants age 18 and older</b>	<b>This authorization must be signed by 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	____/____/____



**Arkansas  
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# Application for Health Insurance

### For Arkansas Blue Cross Use Only

This application was received by:

- C     NW     NE     WC  
 SC     SW     SE     Customer Service  
 Retail Store

Date Stamp \_\_\_\_\_

## 1 WHO IS APPLYING

Read all instructions for Section 1 before completing.

First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Security No.	Height	Weight
				<b>Self</b>				ft. in.	lbs.
								ft. in.	lbs.
								ft. in.	lbs.
								ft. in.	lbs.
								ft. in.	lbs.
								ft. in.	lbs.

## 2 PARENT/GUARDIAN (If policy is only for a child under age 19)

Additional information may be required. Read instructions for Section 2 before completing.

First Name	M.I.	Last Name	Relationship (Check One)
			<input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Guardian <input type="checkbox"/> Father <input type="checkbox"/> Stepfather

## 3 MARITAL STATUS

- Single (including widowed or divorced)       Married (including separated)

## 4 U.S. CITIZENSHIP STATUS

Additional information may be required. Read instructions for Section 4 before completing.

- 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: \_\_\_\_\_

## 5 RESIDENTIAL ADDRESS (Must be permanent address - No P.O. box, please)

Street	City	State	Zip
		AR	

## 6 MAILING ADDRESS (Complete only if different from residential address)

Street or P.O. Box	City	State	Zip
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## 7 BILLING ADDRESS (Complete only if different from residential address)

Street or P.O. Box	City	State	Zip
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## 8 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
--------------------------------	----------------------------------	----------------	--

## 9 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: \_\_\_\_\_

## OFFICE USE ONLY (Do Not Write In This Space)

I.D. No.	Group No.	Effective Date
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## 10 APPLICANT(S) EMPLOYMENT INFORMATION [applicant(s) age 18 and older]

Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Job Duties: \_\_\_\_\_

Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Job Duties: \_\_\_\_\_

## 11 CURRENT/PREVIOUS INSURANCE INFORMATION

- 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: \_\_\_/\_\_\_/\_\_\_.
- Yes  No 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 Medicare? If "yes," please provide name(s) below:
- Name: \_\_\_\_\_
- Name: \_\_\_\_\_

## 12 REQUESTED EFFECTIVE DATE

Arkansas Blue Cross and Blue Shield gives 1<sup>st</sup> of the month and 15<sup>th</sup> of the month effective dates. This is your opportunity to request an effective date that coordinates with the termination of current health insurance coverage.\* While we cannot guarantee a specific requested effective date, we will make every effort to accommodate the request. If your application is approved, the effective date will be assigned based on the date of approval (**see back page for effective date guidelines**). This means retroactive effective dates will not be assigned. **Please check the day you would like your coverage to become effective:**

1<sup>st</sup> of the month  15<sup>th</sup> of the month  No preference  \*Requested effective date: \_\_\_/\_\_\_/\_\_\_

## 13 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): \_\_\_\_\_

## 14 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: \_\_\_\_\_

## 15 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: \_\_\_\_\_

## 16 TYPE OF COVERAGE

Read instructions for Section 16 before completing.

Individual  Individual and Spouse  Individual and Child(ren)  Individual, Spouse and Child(ren)

Yes  No If you are applying for coverage other than "Individual," do you want to continue the application process if one or more applicants is declined or ineligible?

## 17 BILLING MODE

Monthly Bank Draft  
(Must complete attached bank draft form)

Quarterly Invoice

Semi-Annual Invoice

Annual Invoice

## 18 BENEFITS SELECTION

**MUST CHOOSE ONE BOX ONLY**

### Comprehensive Blue PPO III

- \$ 1,000 deductible
- \$ 1,500 deductible
- \$ 2,500 deductible
- \$ 5,000 deductible
- \$ 7,500 deductible
- \$10,000 deductible
- \$15,000 deductible
- \$20,000 deductible
- \$25,000 deductible

### HSA Blue PPO II

- \$ 1,500 individual/  
\$ 3,000 family deductible
- \$ 2,500 individual/  
\$ 5,000 family deductible
- \$ 5,000 individual/  
\$10,000 family deductible

## 19 OPTIONAL BENEFITS SELECTION

### OPTIONAL MATERNITY BENEFITS

Yes, I want to apply for the maternity benefits.

Maternity benefits are payable once the maternity coverage has been in effect for 12 months. This benefit is only available to females age 19 or older. Dependents other than a covered spouse cannot purchase the maternity rider.

## 20 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

## 21 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" to question a. or b., please provide the following:

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

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

## 22 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

## 23 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: \_\_\_\_\_

## 24 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				

## 25 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 circle all conditions that apply.)**

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

## 25 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 25. 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	Date of Last Visit	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					

## 26 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.      \*\*Use "Comments" section on Page 7 if more room is needed for details.

**PLEASE READ BEFORE SIGNING**

I UNDERSTAND: (1) 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, if I am age 19 or older, my application may be approved with no changes, approved but charged a higher premium, and/or approved with non-medical exclusions, or I may be declined for coverage. I will also be subject to a 12-month pre-existing waiting period. **This means conditions existing prior to the effective date of the policy will not be covered until the policy has been in effect for 12 months.** If I am under age 19, my application may be approved with no changes, approved with a higher premium, and/or offered coverage with non-medical exclusions. (2) 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. (3) 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. (4) The COMPANY may phone me for additional information that may help with the timely processing of my application. (5) The Health insurance applied for will not be effective on any proposed insured if there has been a change in the health of any proposed insured between the date this application is signed and the effective date of coverage.

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 the COMPANY may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if intentional misrepresentations of material fact have been provided by me in this application; (c) understand that if intentionally fraudulent misstatements were made, the COMPANY may take legal action at any time; (d) understand my signature authorizes the COMPANY to coordinate benefits under this policy with other insurance I have which is subject to coordination; (e) agree that this application shall be valid without time limit; (f) 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.

**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 application in the state of Arkansas.**

**SIGNATURE SECTION (Please sign appropriate line only)**

Primary Applicant OR Parent/Legal Guardian (if policy for a minor)	<b>X</b>	Date Signed
Spouse (required if applying)	<b>X</b>	Date Signed
Dependent age 18 or older (required if applying)	<b>X</b>	Date Signed
Dependent age 18 or older (required if applying)	<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 primary applicant or the parent/guardian indicated in Section 2, 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

**This section to be completed by sales representative**

Yes  No To the best of your knowledge, will the coverage applied for replace or change any existing hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant?

Sales Rep License No. (required)	<b>X</b>	Sales Representative's Name (Please Print)	Telephone No.
Agency Federal Tax ID No. (If applicable)	<b>X</b>	Sales Representative's Signature	Date Signed

<b>Comments:</b>	<b>OFFICE USE ONLY</b>
------------------	------------------------

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

## Reminders

**To ensure your application is processed as quickly as possible, make sure:**

- All questions are answered.
- All the pages are returned.
- All appropriate signatures and signature dates are provided.

**Have you enclosed your Pre-authorized Monthly Bank Draft form?**

- Did you provide all the requested information?
- Is it signed by the account holder?

**Important Note:** Depending on the date your application is approved, we may not be able to draft your first premium payment. To ensure coverage, please promptly pay any invoice you receive.



**Arkansas  
BlueCross BlueShield**

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# 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 assure your payments are made accurately and timely.**

Depending on the health insurance plan you are applying for and the date your application is approved, we may be able to draft your first month's premium. If so, you will be notified in writing prior to the draft. Once the bank draft is in effect, you will not receive a billing statement.

**Complete the information below.**

## IMPORTANT: PLEASE READ BEFORE SIGNING

I authorize Arkansas Blue Cross and Blue Shield, USABLE Life, and/or 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.

## 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

J. L. Webb  
123 Main Street  
Anytown, USA 12345

DATE \_\_\_\_\_ 1175

PAY TO THE ORDER OF \_\_\_\_\_ \$ \_\_\_\_\_ DOLLARS

MEMO \_\_\_\_\_

| : 123456789 | : 1234567890123 | 1175

**Bank Routing Number**      **Bank Account Number**      **Check Number**

## 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!

**For Office Use Only** (please do not write in this space)

ID NO.	EFFECTIVE DATE

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.



**Arkansas BlueCross BlueShield**  
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**Please 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.

**POLICY EFFECTIVE DATE**

The policy effective date will be the first of the **following month** if the application is approved on the 1st-10th of the **current month**. The policy effective date will be the 15th of the **following month** if the application is approved on the 11th - 25th of the **current month** OR the first of the month **after next** if the application is approved on the 26th - end of the **current month**. Coverage becomes effective upon the date of the policy and contingent upon receipt of premium.

**Approval Date**

1st - 10th

11th - 25th

26th - last day of the month

**Effective Date**

1st of the following month

15th of the following month

1st of the month after next

**Examples**

Approved Jan. 2; effective Feb. 1

Approved Jan. 12; effective Feb. 15

Approved Jan. 27; effective Mar. 1



**Arkansas  
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

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

[www.ArkansasBlueCross.com](http://www.ArkansasBlueCross.com)



Arkansas  
BlueCross BlueShield  
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# Individual/Family Health Insurance Application

**READ ALL INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION. APPLICATION MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.**

- This application 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 application must be completed in dark blue or black ink. Applications 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 application.
- Any **attachments** submitted with the application must be signed and dated.
- **Do not send any money with this application.**
- Please ensure all required parties have signed and dated the application prior to submission.
- **We strongly recommend you make a copy of this completed application for your records.**

## SECTION 1 – WHO IS APPLYING

- Oldest person applying for coverage should be listed on the first line of the application. If applicant is under the age of 19, parent or guardian information should be indicated in Section 2 (*Parent/Guardian*).
- Social Security numbers are **required** for every applicant. If you are applying for coverage for a child less than one year old who does not yet have a Social Security number, you may apply; however, you will be required to submit the Social Security number within 90 days.
- If applying for Individual and Spouse coverage, primary applicant must be age 19 or older and spouse must be age 14 or older.
- If applying for Individual, Spouse and Child(ren) coverage or Individual and Child(ren) coverage, primary applicant must be age 19 or older.
- In “*Relationship*” box, indicate “spouse, son, daughter, stepson, stepdaughter, or dependent child” beside each dependent’s name.
- If applying for coverage for dependent child other than son, daughter, stepson, or stepdaughter, submit copy of appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.
- If primary applicant is under age 19 and does NOT reside with the Parent/Guardian named on this application, custodial parent must also sign the application (see *Signature Section* on Page 7).
- If any dependents are under age 19 and do NOT reside with the primary applicant, the custodial parent must also sign the application (see *Signature Section* on Page 7).

## SECTION 2 – PARENT/GUARDIAN (If policy is only for a child under age 19)

- If applicant is under the age of 19, parent or guardian information must be indicated in this section.
- If applying for coverage as the “Guardian” of a dependent child under the age of 19, please submit appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.

## SECTION 4 – 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 must be submitted 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 will also be contacted by phone to complete a Foreign National Questionnaire.

## SECTION 12 – REQUESTED EFFECTIVE DATE

- The applicant should check preference for 1<sup>st</sup> or 15<sup>th</sup> of the month effective date. This is the applicant’s opportunity to request the effective date coordinates with the termination of current health insurance coverage. While we cannot guarantee a specific requested effective date, we will make every effort to accommodate the request. If the application is approved, the effective date will be assigned based on the date of approval. This means retroactive effective dates will not be assigned.

## SECTION 16 – TYPE OF COVERAGE

- If applicant is applying for coverage other than “Individual,” please indicate if still interested in coverage if one or more applicants is declined or ineligible. If “Yes” is selected, Arkansas Blue Cross will continue the underwriting process if one or more applicants is declined or ineligible. If “No” is selected, Arkansas Blue Cross will close out the application if one or more applicants is declined or ineligible.



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# IMPORTANT:

**We cannot process your application without this completed form.**

## 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 health care 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 health care item or service in relation to the health care 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).

<b>Applicants age 18 and older</b>	<b>This authorization must be signed by 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



**Arkansas  
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

# Application for Health Insurance

## 1 WHO IS APPLYING

Read all instructions for Section 1 before completing.

First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Security No.	Height	Weight
				<b>Self</b>				ft. in.	lbs.
								ft. in.	lbs.
								ft. in.	lbs.
								ft. in.	lbs.
								ft. in.	lbs.
								ft. in.	lbs.

## 2 PARENT/GUARDIAN (If policy is only for a child under age 19)

Additional information may be required. Read instructions for Section 2 before completing.

First Name	M.I.	Last Name	Relationship (Check One)
			<input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Guardian <input type="checkbox"/> Father <input type="checkbox"/> Stepfather

## 3 MARITAL STATUS

Single (including widowed or divorced)       Married (including separated)

## 4 U.S. CITIZENSHIP STATUS

Additional information may be required. Read instructions for Section 4 before completing.

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: \_\_\_\_\_

## 5 RESIDENTIAL ADDRESS (Must be permanent address - No P.O. box, please)

Street	City	State	Zip
		AR	

## 6 MAILING ADDRESS (Complete only if different from residential address)

Street or P.O. Box	City	State	Zip
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## 7 BILLING ADDRESS (Complete only if different from residential address)

Street or P.O. Box	City	State	Zip
--------------------	------	-------	-----

## 8 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
--------------------------------	----------------------------------	----------------	--

## 9 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: \_\_\_\_\_

## OFFICE USE ONLY (Do Not Write In This Space)

I.D. No.	Group No.	Effective Date
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## 10 APPLICANT(S) EMPLOYMENT INFORMATION [applicant(s) age 18 and older]

Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Job Duties: \_\_\_\_\_

Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Job Duties: \_\_\_\_\_

## 11 CURRENT/PREVIOUS INSURANCE INFORMATION

- 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: \_\_\_/\_\_\_/\_\_\_.
- Yes  No 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 Medicare? If "yes," please provide name(s) below:
- Name: \_\_\_\_\_
- Name: \_\_\_\_\_

## 12 REQUESTED EFFECTIVE DATE

Arkansas Blue Cross and Blue Shield gives 1<sup>st</sup> of the month and 15<sup>th</sup> of the month effective dates. This is your opportunity to request an effective date that coordinates with the termination of current health insurance coverage.\* While we cannot guarantee a specific requested effective date, we will make every effort to accommodate the request. If your application is approved, the effective date will be assigned based on the date of approval (**see back page for effective date guidelines**). This means retroactive effective dates will not be assigned. **Please check the day you would like your coverage to become effective:**

1<sup>st</sup> of the month  15<sup>th</sup> of the month  No preference  \*Requested effective date: \_\_\_/\_\_\_/\_\_\_

## 13 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): \_\_\_\_\_

## 14 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: \_\_\_\_\_

## 15 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: \_\_\_\_\_

## 16 TYPE OF COVERAGE

Read instructions for Section 16 before completing.

Individual  Individual and Spouse  Individual and Child(ren)  Individual, Spouse and Child(ren)

Yes  No If you are applying for coverage other than "Individual," do you want to continue the application process if one or more applicants is declined or ineligible?

## 17 BILLING MODE

Monthly Bank Draft  
(Must complete attached bank draft form)

Quarterly Invoice

Semi-Annual Invoice

Annual Invoice

## 18 BENEFITS SELECTION

**MUST CHOOSE ONE BOX ONLY**

### Comprehensive Blue PPO III

- \$ 1,000 deductible
- \$ 1,500 deductible
- \$ 2,500 deductible
- \$ 5,000 deductible
- \$ 7,500 deductible
- \$10,000 deductible
- \$15,000 deductible
- \$20,000 deductible
- \$25,000 deductible

### HSA Blue PPO II

- \$ 1,500 individual/  
\$ 3,000 family deductible
- \$ 2,500 individual/  
\$ 5,000 family deductible
- \$ 5,000 individual/  
\$10,000 family deductible

## 19 OPTIONAL BENEFITS SELECTION

### OPTIONAL MATERNITY BENEFITS

Yes, I want to apply for the maternity benefits.

Maternity benefits are payable once the maternity coverage has been in effect for 12 months. This benefit is only available to females age 19 or older. Dependents other than a covered spouse cannot purchase the maternity rider.

## 20 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

## 21 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" to question a. or b., please provide the following:

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

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

## 22 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

## 23 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: \_\_\_\_\_

## 24 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				

## 25 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 circle all conditions that apply.)**

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

## 25 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 25. 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	Date of Last Visit	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					

## 26 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.      \*\*Use "Comments" section on Page 7 if more room is needed for details.

**PLEASE READ BEFORE SIGNING**

I UNDERSTAND: (1) 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, if I am age 19 or older, my application may be approved with no changes, approved but charged a higher premium, and/or approved with non-medical exclusions, or I may be declined for coverage. I will also be subject to a 12-month pre-existing waiting period. **This means conditions existing prior to the effective date of the policy will not be covered until the policy has been in effect for 12 months.** If I am under age 19, my application may be approved with no changes, approved with a higher premium, and/or offered coverage with non-medical exclusions. (2) 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. (3) 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. (4) The COMPANY may phone me for additional information that may help with the timely processing of my application. (5) The Health insurance applied for will not be effective on any proposed insured if there has been a change in the health of any proposed insured between the date this application is signed and the effective date of coverage.

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 the COMPANY may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if intentional misrepresentations of material fact have been provided by me in this application; (c) understand that if intentionally fraudulent misstatements were made, the COMPANY may take legal action at any time; (d) understand my signature authorizes the COMPANY to coordinate benefits under this policy with other insurance I have which is subject to coordination; (e) agree that this application shall be valid without time limit; (f) 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.

**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 application in the state of Arkansas.**

**SIGNATURE SECTION (Please sign appropriate line only)**

Primary Applicant OR Parent/Legal Guardian (if policy for a minor)	<b>X</b>	Date Signed
Spouse (required if applying)	<b>X</b>	Date Signed
Dependent age 18 or older (required if applying)	<b>X</b>	Date Signed
Dependent age 18 or older (required if applying)	<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 primary applicant or the parent/guardian indicated in Section 2, 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

**Comments:**

**OFFICE USE ONLY**

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

## Reminders

**To ensure your application is processed as quickly as possible, make sure:**

- All questions are answered.
- All the pages are returned.
- All appropriate signatures and signature dates are provided.

**Have you enclosed your Pre-authorized Monthly Bank Draft form?**

- Did you provide all the requested information?
- Is it signed by the account holder?

**Important Note:** Depending on the date your application is approved, we may not be able to draft your first premium payment. To ensure coverage, please promptly pay any invoice you receive.



**Arkansas  
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

# 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 assure your payments are made accurately and timely.**

Depending on the health insurance plan you are applying for and the date your application is approved, we may be able to draft your first month's premium. If so, you will be notified in writing prior to the draft. Once the bank draft is in effect, you will not receive a billing statement.

**Complete the information below.**

## IMPORTANT: PLEASE READ BEFORE SIGNING

I authorize Arkansas Blue Cross and Blue Shield, USABLE Life, and/or 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.

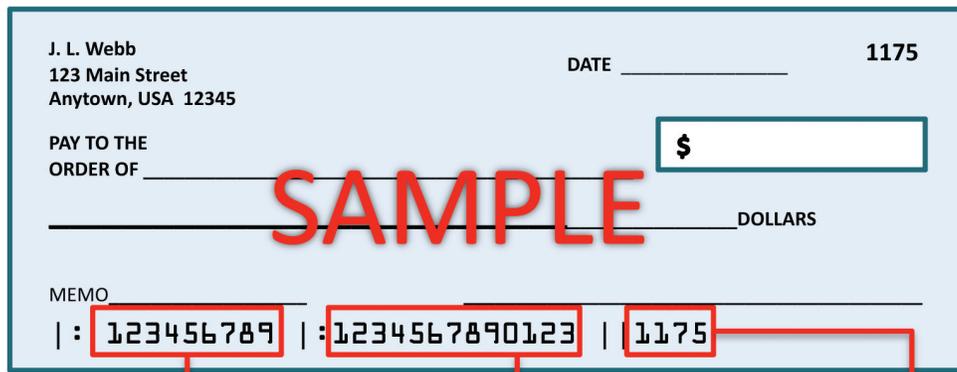
## PROPOSED INSURED'S INFORMATION

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



Bank Routing Number

Bank Account Number

Check Number

## 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!

**For Office Use Only** (please do not write in this space)

ID NO.

EFFECTIVE DATE



**Arkansas BlueCross BlueShield**

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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.

**Please 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.

**POLICY EFFECTIVE DATE**

The policy effective date will be the first of the **following month** if the application is approved on the 1st-10th of the **current month**. The policy effective date will be the 15th of the **following month** if the application is approved on the 11th - 25th of the **current month** OR the first of the month **after next** if the application is approved on the 26th - end of the **current month**. Coverage becomes effective upon the date of the policy and contingent upon receipt of premium.

**Approval Date**

1st - 10th

11th - 25th

26th - last day of the month

**Effective Date**

1st of the following month

15th of the following month

1st of the month after next

**Examples**

Approved Jan. 2; effective Feb. 1

Approved Jan. 12; effective Feb. 15

Approved Jan. 27; effective Mar. 1



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

[www.ArkansasBlueCross.com](http://www.ArkansasBlueCross.com)



Arkansas  
BlueCross BlueShield

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# List Bill Individual/Family Health Insurance Application

**READ ALL INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION. APPLICATION MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.**

- This application 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 application must be completed in dark blue or black ink. Applications 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 application.
- Any **attachments** submitted with the application must be signed and dated.
- **Do not send any money with this application.**
- Please ensure all required parties have signed and dated the application prior to submission.
- **We strongly recommend you make a copy of this completed application for your records.**

## SECTION 1 – WHO IS APPLYING

- Oldest person applying for coverage should be listed on the first line of the application. If applicant is under the age of 19, parent or guardian information should be indicated in Section 2 (*Parent/Guardian*).
- Social Security numbers are **required** for every applicant. If you are applying for coverage for a child less than one year old who does not yet have a Social Security number, you may apply; however, you will be required to submit the Social Security number within 90 days.
- If applying for Individual and Spouse coverage, primary applicant must be age 19 or older and spouse must be age 14 or older.
- If applying for Individual, Spouse and Child(ren) coverage or Individual and Child(ren) coverage, primary applicant must be age 19 or older.
- In "*Relationship*" box, indicate "spouse, son, daughter, stepson, stepdaughter, or dependent child" beside each dependent's name.
- If applying for coverage for dependent child other than son, daughter, stepson, or stepdaughter, submit copy of appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.
- If primary applicant is under age 19 and does NOT reside with the Parent/Guardian named on this application, custodial parent must also sign the application (see *Signature Section* on Page 8).
- If any dependents are under age 19 and do NOT reside with the primary applicant, the custodial parent must also sign the application (see *Signature Section* on Page 8).

## SECTION 2 – PARENT/GUARDIAN (If policy is only for a child under age 19)

- If applicant is under the age of 19, parent or guardian information must be indicated in this section.
- If applying for coverage as the "Guardian" of a dependent child under the age of 19, please submit appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.

## SECTION 4 – 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 must be submitted 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 will also be contacted by phone to complete a Foreign National Questionnaire.

## SECTION 15 – TYPE OF COVERAGE

- If applicant is applying for coverage other than "Individual," please indicate if still interested in coverage if one or more applicants is declined or ineligible. If "Yes" is selected, Arkansas Blue Cross will continue the underwriting process if one or more applicants is declined or ineligible. If "No" is selected, Arkansas Blue Cross will close out the application if one or more applicants is declined or ineligible.



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# IMPORTANT:

**We cannot process your application without this completed form.**

## 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 health care 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 health care item or service in relation to the health care 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).

<b>Applicants age 18 and older</b>	<b>This authorization must be signed by 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	____/____/____



## 10 APPLICANT(S) EMPLOYMENT INFORMATION [applicant(s) age 18 and older]

Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Job Duties: \_\_\_\_\_

Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Job Duties: \_\_\_\_\_

## 11 CURRENT/PREVIOUS INSURANCE INFORMATION

- 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: \_\_\_/\_\_\_/\_\_\_.
- Yes  No 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 Medicare? If "yes," please provide name(s) below:
- Name: \_\_\_\_\_
- Name: \_\_\_\_\_

## 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): \_\_\_\_\_

## 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: \_\_\_\_\_

## 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: \_\_\_\_\_

## 15 TYPE OF COVERAGE

- Individual       Individual and Spouse       Individual and Child(ren)       Individual, Spouse and Child(ren)

- Yes     No    If you are applying for coverage other than "Individual," are you interested in coverage if one or more applicants is declined or ineligible?

## 16 BENEFITS SELECTION

**MUST CHOOSE ONE BOX ONLY**

### Comprehensive Blue PPO III

- \$ 1,000 deductible
- \$ 1,500 deductible
- \$ 2,500 deductible
- \$ 5,000 deductible
- \$ 7,500 deductible
- \$10,000 deductible
- \$15,000 deductible
- \$20,000 deductible
- \$25,000 deductible

### HSA Blue PPO II

- \$ 1,500 individual/  
\$ 3,000 family deductible
- \$ 2,500 individual/  
\$ 5,000 family deductible
- \$ 5,000 individual/  
\$10,000 family deductible

## 17 OPTIONAL BENEFITS SELECTION

### OPTIONAL MATERNITY BENEFITS

- Yes, I want to apply for the maternity benefits.

Maternity benefits are payable once the maternity coverage has been in effect for 12 months. This benefit is only available to females age 19 or older. Dependents other than a covered spouse cannot purchase the maternity rider.

## 18 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

## 19 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" to question a. or b., please provide the following:**

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

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

## 20 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

## 21 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: \_\_\_\_\_

## 22 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				

## 23 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 circle all conditions that apply.)**

### A. BRAIN OR NERVOUS SYSTEM DISORDERS

- Alzheimer's disease or senile dementia
- Amyotrophic lateral sclerosis (Lou Gehrig's disease)
- Cerebral palsy
- Concussion or brain injury
- Convulsions, epilepsy or seizures
- Headaches or migraines
- Meningitis
- Multiple sclerosis, muscular dystrophy or myasthenia gravis
- Neuritis
- Paralysis or palsy
- Parkinson's disease
- Polyneuritis
- Vertigo, fainting or dizziness
- Any other disorder of the brain or nervous system
- None of the above apply to any applicant(s)**

### B. CIRCULATORY

- Abnormal cholesterol/lipids
- Angina, heart attack, myocardial infarction
- Arteriosclerosis, atherosclerosis, coronary artery disease, stent placement or angioplasty
- Cerebrovascular accident (stroke), including transient ischemic attack (TIA)
- Chest pain, shortness of breath, heart murmur, palpitation of the heart, ablation, rheumatic fever
- Heart bypass surgery, pacemaker implant
- Heart or vein/artery surgery
- High blood pressure
- Hemophilia
- Valve repair/replacement
- Any other disorder of the heart, blood, blood vessels or circulatory system
- None of the above apply to any applicant(s)**

### C. DIGESTIVE

- Cirrhosis
- Crohn's disease or ulcerative colitis
- Gastric bypass surgery or other weight loss procedure
- Gastric or duodenal ulcer
- Hepatitis
- Hernia, hemorrhoids
- Irritable bowel syndrome or gastric esophageal reflux disorder (GERD)
- Pancreatitis
- Pyloric stenosis
- Any other disorder of stomach, intestines, liver, gallbladder or rectum
- None of the above apply to any applicant(s)**

### D. KIDNEY, URINARY, REPRODUCTIVE

- Abnormal pap smear
- Bladder or renal stones
- Cesarean section or miscarriage
- Dialysis
- Nephritis
- Nephrotic syndrome, renal disease or failure
- Sexually transmitted disease
- Sugar, blood or protein in urine
- Any other disorder of the kidneys or urinary tract
- Any other disorder of the male reproductive organs, including prostate
- Any other disorder of the female reproductive organs, including ovaries or breasts
- None of the above apply to any applicant(s)**

### E. RESPIRATORY

- Allergies, asthma or bronchitis
- Chronic pulmonary disease, emphysema, lung disease or respiratory syncytial virus (RSV)
- Obstructive or reactive airway disorder
- Sleep apnea, cpap, bipap or vpap
- Any other disorder of the lungs, bronchial tubes or respiratory system
- None of the above apply to any applicant(s)**

### F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS

- Anemia
- Cancer, leukemia or malignancy of any kind
- Hodgkin's or Non-Hodgkin's disease
- Melanoma, neoplasm or tumor
- Any other disorder of the lymphatic system
- Any other disorder of the skin
- None of the above apply to any applicant(s)**

### G. GLANDULAR DISORDERS

- Adrenal disorders
- Diabetes, abnormal glucose
- Goiter or thyroid disease
- Any disorder of the pancreas
- None of the above apply to any applicant(s)**

### H. MUSCULOSKELETAL

- Arthritis, osteoarthritis, degenerative joint or disc disease
- Back pain and/or neck pain
- Chronic fatigue
- Connective tissue disorder
- Disease or disorder of the joints: knee(s), shoulder(s), elbow(s), wrist(s), other
- Fibromyalgia, bursitis or tendonitis

### MUSCULOSKELETAL (cont.)

- Fracture(s) or broken bone(s)  
Exposed bone  Yes  No
- Gout
- Lupus, systemic
- Temporomandibular joint disorder (TMJ/TMD) or craniomandibular disorder
- Any other disorder of the muscles, bones or joints to include chiropractic care
- None of the above apply to any applicant(s)**

### I. EARS/EYES/NOSE/THROAT

- Cataracts or glaucoma
- Meniere's disease
- Nasal septal defect
- Sinusitis, tonsillitis or otitis media
- Any other disorder of the eyes, ears, nose, throat or esophagus
- None of the above apply to any applicant(s)**

### J. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE

- Anxiety, insomnia, sleep disorder, depression, emotional problems or nervous disorder
- Attempted suicide
- Counseling or psychiatric treatment (in-patient or out-patient)
- Bipolar disorder, obsessive compulsive disorder or developmental disorder
- Eating disorder
- Any other mental, emotional disorder or situation, including ADD/ADHD
- None of the above apply to any applicant(s)**

### K. OTHER

- Current patient in a hospital or nursing home
- Pending Surgery Surgery Date: \_\_/\_\_/\_\_
- Sarcoidosis
- Breast implants  
 Saline  Silicone Surgery Date: \_\_/\_\_/\_\_
- Any other implant(s), prosthetic device(s), internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents)
- Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder or HIV
- Transplant recipient
- Any injury, deformity, incapacitation, disease or condition not listed elsewhere
- None of the above apply to any applicant(s)**

## 23 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 23. 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	Date of Last Visit	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					

## 24 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.

\*\*Use "Comments" section on Page 8 if more room is needed for details.

## PLEASE READ BEFORE SIGNING

By completing this list bill application, which authorizes my employer to remit my premium to Arkansas Blue Cross and Blue Shield (hereafter referred to as the COMPANY), I understand and agree: (1) My employer will payroll deduct my premium from my compensation and remit the premium amount to COMPANY. (2) My employer is not acting as an agent of COMPANY but is, instead, at all times acting as my representative. (3) I am responsible for the payment of the premium. Therefore, if my employer fails to submit the required amounts when due, all coverage will terminate as of the due date. (4) If my employer fails to submit the required amounts when due, COMPANY has no obligation to seek payment directly from me. (5) I will not hold COMPANY liable for loss of coverage or benefits due to failure by my employer to remit payment in a timely manner. (6) My coverage is not dependent upon this billing arrangement; therefore, I may change to having COMPANY bill me directly with 15 days advance written notice to my employer and COMPANY. (7) I understand that termination of my employment shall terminate payroll deduction and employer remittance of premium to COMPANY. (8) I understand that my employer or COMPANY may terminate this arrangement by giving me written notice, but this will not terminate my insurance coverage. (9) If this payroll deduction and premium remittance is terminated, in order for me to keep my insurance coverage in force, I must make premium payments directly to COMPANY.

I UNDERSTAND: (1) 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, if I am age 19 or older, my application may be approved with no changes, approved but charged a higher premium, and/or approved with non-medical exclusions, or I may be declined for coverage. If I am under age 19, my application may be approved with no changes, approved with a higher premium, and/or offered coverage with non-medical exclusions. (2) **If I am age 19 or older, I will not have any benefits provided for 12 months for the treatment of any condition which existed before the effective date of my coverage.** (3) The agent or broker involved in this insurance transaction may receive compensation from 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. (4) 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. (5) The COMPANY may phone me for additional information that may help with the timely processing of my application. (6) The Health insurance applied for will not be effective on any proposed insured if there has been a change in the health of any proposed insured between the date this application is signed and the effective date of coverage.

In signing, 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 the COMPANY may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if intentional misrepresentations of material fact have been provided by me in this application; (c) understand that if intentionally fraudulent misstatements were made, the COMPANY may take legal action at any time; (d) understand my signature authorizes the COMPANY to coordinate benefits under this policy with other insurance I have which is subject to coordination; (e) agree that this application shall be valid without time limit; (f) 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.

**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 application in the state of Arkansas.

**SIGNATURE SECTION (Please sign appropriate line only)**

Primary Applicant <b>OR</b> Parent/Legal Guardian (if policy for a minor)	<b>X</b>	Date Signed
Spouse (required if applying)	<b>X</b>	Date Signed
Dependent age 18 or older (required if applying)	<b>X</b>	Date Signed
Dependent age 18 or older (required if applying)	<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 primary applicant or the parent/guardian indicated in Section 2, 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

**This section to be completed by sales representative**

Yes  No To the best of your knowledge, will the coverage applied for replace or change any existing hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant?

Sales Rep License No. (required)	<b>X</b>	Sales Representative's Name (Please Print)	Telephone No.
Agency Federal Tax ID No. (if applicable)	<b>X</b>	Sales Representative's Signature	Date Signed

**Comments:**

**OFFICE USE ONLY**

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

## Reminders

***To ensure your application is processed as quickly as possible, make sure:***

- All questions are answered.
- All the pages are returned.
- All appropriate signatures and signature dates are provided.

***Have you enclosed your Pre-authorized Monthly Bank Draft form?***

- Did you provide all the requested information?
- Is it signed by the account holder?

**Important Note:** Depending on the date your application is approved, we may not be able to draft your first premium payment. To ensure coverage, please promptly pay any invoice you receive.

Please 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.

## POLICY EFFECTIVE DATE

The policy effective date will be the first of the **following month** if the application is approved on the 1st-10th of the **current month**. The policy effective date will be the 1st of the **month after next** if the application is approved on the 11th through the end of the **current month**.

### Approval Date

1st - 10th

11th - last day of the month

### Effective Date

1st of the following month

1st of the month after next

### Examples

Approved Jan. 2; effective Feb. 1

Approved Jan. 27; effective Mar. 1



# Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

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

[www.ArkansasBlueCross.com](http://www.ArkansasBlueCross.com)



Arkansas  
BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

# List Bill Individual/Family Health Insurance Application

**READ ALL INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION. APPLICATION MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.**

- This application 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 application must be completed in dark blue or black ink. Applications 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 application.
- Any **attachments** submitted with the application must be signed and dated.
- **Do not send any money with this application.**
- Please ensure all required parties have signed and dated the application prior to submission.
- **We strongly recommend you make a copy of this completed application for your records.**

## SECTION 1 – WHO IS APPLYING

- Oldest person applying for coverage should be listed on the first line of the application. If applicant is under the age of 19, parent or guardian information should be indicated in Section 2 (*Parent/Guardian*).
- Social Security numbers are **required** for every applicant. If you are applying for coverage for a child less than one year old who does not yet have a Social Security number, you may apply; however, you will be required to submit the Social Security number within 90 days.
- If applying for Individual and Spouse coverage, primary applicant must be age 19 or older and spouse must be age 14 or older.
- If applying for Individual, Spouse and Child(ren) coverage or Individual and Child(ren) coverage, primary applicant must be age 19 or older.
- In "*Relationship*" box, indicate "spouse, son, daughter, stepson, stepdaughter, or dependent child" beside each dependent's name.
- If applying for coverage for dependent child other than son, daughter, stepson, or stepdaughter, submit copy of appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.
- If primary applicant is under age 19 and does NOT reside with the Parent/Guardian named on this application, custodial parent must also sign the application (see *Signature Section* on Page 8).
- If any dependents are under age 19 and do NOT reside with the primary applicant, the custodial parent must also sign the application (see *Signature Section* on Page 8).

## SECTION 2 – PARENT/GUARDIAN (If policy is only for a child under age 19)

- If applicant is under the age of 19, parent or guardian information must be indicated in this section.
- If applying for coverage as the "Guardian" of a dependent child under the age of 19, please submit appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.

## SECTION 4 – 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 must be submitted 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 will also be contacted by phone to complete a Foreign National Questionnaire.

## SECTION 15 – TYPE OF COVERAGE

- If applicant is applying for coverage other than "Individual," please indicate if still interested in coverage if one or more applicants is declined or ineligible. If "Yes" is selected, Arkansas Blue Cross will continue the underwriting process if one or more applicants is declined or ineligible. If "No" is selected, Arkansas Blue Cross will close out the application if one or more applicants is declined or ineligible.



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# IMPORTANT:

**We cannot process your application without this completed form.**

## 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 health care 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 health care item or service in relation to the health care 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).

<b>Applicants age 18 and older</b>	<b>This authorization must be signed by 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	____/____/____



**Arkansas  
BlueCross BlueShield**

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# Application for Health Insurance

## 1 WHO IS APPLYING

Read all instructions for Section 1 before completing.

First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Security No.	Height	Weight
				<b>Self</b>				ft. in.	lbs.
								ft. in.	lbs.
								ft. in.	lbs.
								ft. in.	lbs.
								ft. in.	lbs.
								ft. in.	lbs.

## 2 PARENT/GUARDIAN (If policy is only for a child under age 19)

Additional information may be required. Read instructions for Section 2 before completing.

First Name	M.I.	Last Name	Relationship (Check One)
			<input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Guardian <input type="checkbox"/> Father <input type="checkbox"/> Stepfather

## 3 MARITAL STATUS

Single (including widowed or divorced)       Married (including separated)

## 4 U.S. CITIZENSHIP STATUS

Additional information may be required. Read instructions for Section 4 before completing.

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: \_\_\_\_\_

## 5 RESIDENTIAL ADDRESS (Must be permanent address - No P.O. box, please)

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
AR

## 6 MAILING ADDRESS (Complete only if different from residential address)

Street or P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## 7 BILLING MODE

List Bill #: \_\_\_\_\_

## 8 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

## 9 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: \_\_\_\_\_

## OFFICE USE ONLY (Do Not Write In This Space)

I.D. No.	Group No.	Effective Date

## 10 APPLICANT(S) EMPLOYMENT INFORMATION [applicant(s) age 18 and older]

Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Job Duties: \_\_\_\_\_

Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Job Duties: \_\_\_\_\_

## 11 CURRENT/PREVIOUS INSURANCE INFORMATION

- 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: \_\_\_/\_\_\_/\_\_\_.
- Yes  No 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 Medicare? If "yes," please provide name(s) below:
- Name: \_\_\_\_\_
- Name: \_\_\_\_\_

## 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): \_\_\_\_\_

## 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: \_\_\_\_\_

## 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: \_\_\_\_\_

## 15 TYPE OF COVERAGE

- Individual       Individual and Spouse       Individual and Child(ren)       Individual, Spouse and Child(ren)

- Yes     No    If you are applying for coverage other than "Individual," are you interested in coverage if one or more applicants is declined or ineligible?

## 16 BENEFITS SELECTION

**MUST CHOOSE ONE BOX ONLY**

### Comprehensive Blue PPO III

- \$ 1,000 deductible
- \$ 1,500 deductible
- \$ 2,500 deductible
- \$ 5,000 deductible
- \$ 7,500 deductible
- \$10,000 deductible
- \$15,000 deductible
- \$20,000 deductible
- \$25,000 deductible

### HSA Blue PPO II

- \$ 1,500 individual/  
\$ 3,000 family deductible
  
- \$ 2,500 individual/  
\$ 5,000 family deductible
  
- \$ 5,000 individual/  
\$10,000 family deductible

## 17 OPTIONAL BENEFITS SELECTION

### OPTIONAL MATERNITY BENEFITS

- Yes, I want to apply for the maternity benefits.

Maternity benefits are payable once the maternity coverage has been in effect for 12 months. This benefit is only available to females age 19 or older. Dependents other than a covered spouse cannot purchase the maternity rider.

## 18 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

## 19 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" to question a. or b., please provide the following:

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

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

## 20 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

## 21 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: \_\_\_\_\_

## 22 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				

## 23 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 circle all conditions that apply.)**

### A. BRAIN OR NERVOUS SYSTEM DISORDERS

- Alzheimer's disease or senile dementia
- Amyotrophic lateral sclerosis (Lou Gehrig's disease)
- Cerebral palsy
- Concussion or brain injury
- Convulsions, epilepsy or seizures
- Headaches or migraines
- Meningitis
- Multiple sclerosis, muscular dystrophy or myasthenia gravis
- Neuritis
- Paralysis or palsy
- Parkinson's disease
- Polyneuritis
- Vertigo, fainting or dizziness
- Any other disorder of the brain or nervous system
- None of the above apply to any applicant(s)**

### B. CIRCULATORY

- Abnormal cholesterol/lipids
- Angina, heart attack, myocardial infarction
- Arteriosclerosis, atherosclerosis, coronary artery disease, stent placement or angioplasty
- Cerebrovascular accident (stroke), including transient ischemic attack (TIA)
- Chest pain, shortness of breath, heart murmur, palpitation of the heart, ablation, rheumatic fever
- Heart bypass surgery, pacemaker implant
- Heart or vein/artery surgery
- High blood pressure
- Hemophilia
- Valve repair/replacement
- Any other disorder of the heart, blood, blood vessels or circulatory system
- None of the above apply to any applicant(s)**

### C. DIGESTIVE

- Cirrhosis
- Crohn's disease or ulcerative colitis
- Gastric bypass surgery or other weight loss procedure
- Gastric or duodenal ulcer
- Hepatitis
- Hernia, hemorrhoids
- Irritable bowel syndrome or gastric esophageal reflux disorder (GERD)
- Pancreatitis
- Pyloric stenosis
- Any other disorder of stomach, intestines, liver, gallbladder or rectum
- None of the above apply to any applicant(s)**

### D. KIDNEY, URINARY, REPRODUCTIVE

- Abnormal pap smear
- Bladder or renal stones
- Cesarean section or miscarriage
- Dialysis
- Nephritis
- Nephrotic syndrome, renal disease or failure
- Sexually transmitted disease
- Sugar, blood or protein in urine
- Any other disorder of the kidneys or urinary tract
- Any other disorder of the male reproductive organs, including prostate
- Any other disorder of the female reproductive organs, including ovaries or breasts
- None of the above apply to any applicant(s)**

### E. RESPIRATORY

- Allergies, asthma or bronchitis
- Chronic pulmonary disease, emphysema, lung disease or respiratory syncytial virus (RSV)
- Obstructive or reactive airway disorder
- Sleep apnea, cpap, bipap or vpap
- Any other disorder of the lungs, bronchial tubes or respiratory system
- None of the above apply to any applicant(s)**

### F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS

- Anemia
- Cancer, leukemia or malignancy of any kind
- Hodgkin's or Non-Hodgkin's disease
- Melanoma, neoplasm or tumor
- Any other disorder of the lymphatic system
- Any other disorder of the skin
- None of the above apply to any applicant(s)**

### G. GLANDULAR DISORDERS

- Adrenal disorders
- Diabetes, abnormal glucose
- Goiter or thyroid disease
- Any disorder of the pancreas
- None of the above apply to any applicant(s)**

### H. MUSCULOSKELETAL

- Arthritis, osteoarthritis, degenerative joint or disc disease
- Back pain and/or neck pain
- Chronic fatigue
- Connective tissue disorder
- Disease or disorder of the joints: knee(s), shoulder(s), elbow(s), wrist(s), other
- Fibromyalgia, bursitis or tendonitis

### MUSCULOSKELETAL (cont.)

- Fracture(s) or broken bone(s)  
Exposed bone  Yes  No
- Gout
- Lupus, systemic
- Temporomandibular joint disorder (TMJ/TMD) or craniomandibular disorder
- Any other disorder of the muscles, bones or joints to include chiropractic care
- None of the above apply to any applicant(s)**

### I. EARS/EYES/NOSE/THROAT

- Cataracts or glaucoma
- Meniere's disease
- Nasal septal defect
- Sinusitis, tonsillitis or otitis media
- Any other disorder of the eyes, ears, nose, throat or esophagus
- None of the above apply to any applicant(s)**

### J. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE

- Anxiety, insomnia, sleep disorder, depression, emotional problems or nervous disorder
- Attempted suicide
- Counseling or psychiatric treatment (in-patient or out-patient)
- Bipolar disorder, obsessive compulsive disorder or developmental disorder
- Eating disorder
- Any other mental, emotional disorder or situation, including ADD/ADHD
- None of the above apply to any applicant(s)**

### K. OTHER

- Current patient in a hospital or nursing home
- Pending Surgery Surgery Date: \_\_/\_\_/\_\_
- Sarcoidosis
- Breast implants  
 Saline  Silicone Surgery Date: \_\_/\_\_/\_\_
- Any other implant(s), prosthetic device(s), internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents)
- Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder or HIV
- Transplant recipient
- Any injury, deformity, incapacitation, disease or condition not listed elsewhere
- None of the above apply to any applicant(s)**

## 23 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 23. 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	Date of Last Visit	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					

## 24 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.

\*\*Use "Comments" section on Page 8 if more room is needed for details.

## PLEASE READ BEFORE SIGNING

By completing this list bill application, which authorizes my employer to remit my premium to Arkansas Blue Cross and Blue Shield (hereafter referred to as the COMPANY), I understand and agree: (1) My employer will payroll deduct my premium from my compensation and remit the premium amount to COMPANY. (2) My employer is not acting as an agent of COMPANY but is, instead, at all times acting as my representative. (3) I am responsible for the payment of the premium. Therefore, if my employer fails to submit the required amounts when due, all coverage will terminate as of the due date. (4) If my employer fails to submit the required amounts when due, COMPANY has no obligation to seek payment directly from me. (5) I will not hold COMPANY liable for loss of coverage or benefits due to failure by my employer to remit payment in a timely manner. (6) My coverage is not dependent upon this billing arrangement; therefore, I may change to having COMPANY bill me directly with 15 days advance written notice to my employer and COMPANY. (7) I understand that termination of my employment shall terminate payroll deduction and employer remittance of premium to COMPANY. (8) I understand that my employer or COMPANY may terminate this arrangement by giving me written notice, but this will not terminate my insurance coverage. (9) If this payroll deduction and premium remittance is terminated, in order for me to keep my insurance coverage in force, I must make premium payments directly to COMPANY.

I UNDERSTAND: (1) 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, if I am age 19 or older, my application may be approved with no changes, approved but charged a higher premium, and/or approved with non-medical exclusions, or I may be declined for coverage. If I am under age 19, my application may be approved with no changes, approved with a higher premium, and/or offered coverage with non-medical exclusions. (2) **If I am age 19 or older, I will not have any benefits provided for 12 months for the treatment of any condition which existed before the effective date of my coverage.** (3) The agent or broker involved in this insurance transaction may receive compensation from 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. (4) 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. (5) The COMPANY may phone me for additional information that may help with the timely processing of my application. (6) The Health insurance applied for will not be effective on any proposed insured if there has been a change in the health of any proposed insured between the date this application is signed and the effective date of coverage.

In signing, 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 the COMPANY may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if intentional misrepresentations of material fact have been provided by me in this application; (c) understand that if intentionally fraudulent misstatements were made, the COMPANY may take legal action at any time; (d) understand my signature authorizes the COMPANY to coordinate benefits under this policy with other insurance I have which is subject to coordination; (e) agree that this application shall be valid without time limit; (f) 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.

**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 application in the state of Arkansas.

**SIGNATURE SECTION (Please sign appropriate line only)**

Primary Applicant <b>OR</b> Parent/Legal Guardian (if policy for a minor)	<b>X</b>	Date Signed
Spouse (required if applying)	<b>X</b>	Date Signed
Dependent age 18 or older (required if applying)	<b>X</b>	Date Signed
Dependent age 18 or older (required if applying)	<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 primary applicant or the parent/guardian indicated in Section 2, 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

Comments:

**OFFICE USE ONLY**

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

## Reminders

***To ensure your application is processed as quickly as possible, make sure:***

- All questions are answered.
- All the pages are returned.
- All appropriate signatures and signature dates are provided.

***Have you enclosed your Pre-authorized Monthly Bank Draft form?***

- Did you provide all the requested information?
- Is it signed by the account holder?

**Important Note:** Depending on the date your application is approved, we may not be able to draft your first premium payment. To ensure coverage, please promptly pay any invoice you receive.

Please 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.

## POLICY EFFECTIVE DATE

The policy effective date will be the first of the **following month** if the application is approved on the 1st-10th of the **current month**. The policy effective date will be the 1st of the **month after next** if the application is approved on the 11th through the end of the **current month**.

### Approval Date

1st - 10th

11th - last day of the month

### Effective Date

1st of the following month

1st of the month after next

### Examples

Approved Jan. 2; effective Feb. 1

Approved Jan. 27; effective Mar. 1



# Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

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

[www.ArkansasBlueCross.com](http://www.ArkansasBlueCross.com)



# *Individual/Family Health Insurance Non-Underwriting Change Form*

**READ ALL INSTRUCTIONS BEFORE COMPLETING THIS CHANGE FORM. 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 change 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.
- 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.**

**\*\*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).

## INSTRUCTION SHEET

**Changes to your policy can only be made during the annual open enrollment period, unless the change is a result of 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 #. This information must be entered correctly under Section 1 in order to process your request.**

**Effective Date:** The effective date for any changes requested from a “qualifying life event” will be the next available effective date following approval. Changes requested during the annual open enrollment period will become effective the following January (the 1<sup>st</sup> or 15<sup>th</sup> of the month, depending on your billing date).

**Billing Change:** Any request made to change your billing will be based on the current billing date of your policy.

### Section 3 – Address Changes

Any change to your current address information can be completed in **Section 3 – Address Changes**. 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 Explanations of Benefits (EOBs) will be mailed to this address.

**Billing** – All billing invoices will be mailed to this address.

### Section 4 – Policy Change Eligibility

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:

- 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)

**Please ensure all documentation is included.**

### Section 5 – Name Change

Documentation is required for any name change request. Please complete **Section 5 – Name Change** and attach appropriate documentation such as, a copy of your marriage license, divorce decree, adoption papers or other court papers to support the change.

### Section 7 – 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 **Section 7 – Delete Person(s) From The Policy**.

**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 9 – 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.

### Section 8 – Ownership Changes

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 **Section 8 – Ownership Change**. Both the current policyholder and new policyholder must sign the change form.

### Section 11 – Benefit Changes

- 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**.



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

# Non-Underwriting Change Form For Current Policy

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

## 1 CURRENT POLICYHOLDER INFORMATION

Member ID: \_\_\_\_\_ Group Number: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_

## 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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### CHANGES TO BE MADE

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

## 3 ADDRESS CHANGES

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

## 4 POLICY CHANGE ELIGIBILITY

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

- |  |             |  |             |  |             |
|--|-------------|--|-------------|--|-------------|
| <input type="checkbox"/> 1-Annual Open Enrollment Period | <b>Date</b> | <input type="checkbox"/> 7-New Guardianship/Legal custody/court order to add child | <b>Date</b> | <input type="checkbox"/> 10-Military Leave                       | <b>Date</b> |
| <input type="checkbox"/> 2-Birth                         | _____       | <input type="checkbox"/> 8-Loss of employer-sponsored health coverage              | _____       | <input type="checkbox"/> 11-Military Reinstatement               | _____       |
| <input type="checkbox"/> 3-Adoption                      | _____       | <input type="checkbox"/> 9-Involuntary loss of other health coverage               | _____       | <input type="checkbox"/> 12-Other (Give specific details & date) | _____       |
| <input type="checkbox"/> 4-Death                         | _____       |  |             |  |             |
| <input type="checkbox"/> 5-Marriage                      | _____       |  |             |  |             |
| <input type="checkbox"/> 6-Divorce or Legal Separation   | _____       |  |             |  |             |

NOTE: If Change Form is **not** received during Open Enrollment Period, you must submit appropriate documentation with Change Form to confirm qualifying life event (i.e. copy of birth or death certificate, copy of marriage license, Certificate of Creditable Coverage from previous insurance company, guardianship/custody documentation, etc.)

## 5 NAME CHANGE

Additional documentation required. Read instructions for Section 5 on the instruction sheet before completing.

From: First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_  
To: First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

## 6 BILLING CHANGE

- Monthly Bank Draft (Must complete attached bank draft form)  Quarterly Invoice  Semi-Annual Invoice  Annual Invoice

## 7 DELETE PERSON(S) FROM THE POLICY

First Name	M.I.	Last Name	Suffix	Date of Birth

## 8 OWNERSHIP CHANGE

From: First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_  
To: First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

## 9 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

Primary Phone Number ( ) ( )	Alternate Phone Number ( ) ( )	E-Mail Address
---------------------------------	-----------------------------------	----------------

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       Quarterly Invoice       Semi-Annual Invoice       Annual Invoice  
(Must complete attached bank draft form)

## 10 DELETE BENEFITS (see Products in section 11 for other optional riders)

Term Life Insurance     Maternity Rider       Mental Health Parity  
(Only applicable for Comprehensive Blue PPO and Comprehensive Blue PPO II)

## 11 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.**

**▲ AccessBlue PPO Group # 700101-700104 or 700201-700204 - Grandfathered**

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

**▲ AccessBlue PPO Group # 300101-300104 or 300201-300204 - Non-Grandfathered**

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

**▲ Basic Blue PPO Group # 710000 or 720000 - Grandfathered**

Delete the following benefit:       Physician Office Visits Rider       Prescription Drugs Rider

**▲ BlueCare PPO Group # 600010-600016 or 600020-600026 - Grandfathered**

**BlueCare PPO Plus Group # 600030-600036 or 600040-600046 - Grandfathered**

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

Increase my calendar-year coinsurance maximum to:       \$2,000

\*\$2,500 has no coinsurance maximum

## 11 BENEFIT CHANGES (continued)

**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 Choice Group # 771000-771023 or 781000-781020 - Grandfathered

Increase my calendar-year deductible and benefit to:

#### \$500 Deductible Options

- \$1,000 OOP\* coinsurance maximum and EC Rx plan
- \$2,000 OOP\* coinsurance maximum and CC Rx plan
- \$2,000 OOP\* coinsurance maximum and EC Rx plan

#### \$1,000 Deductible Options

- \$1,000 OOP\* coinsurance maximum and CC Rx plan
- \$1,000 OOP\* coinsurance maximum and EC Rx plan
- \$2,000 OOP\* coinsurance maximum and CC Rx plan
- \$2,000 OOP\* coinsurance maximum and EC Rx plan

#### \$2,500 Deductible Options

- No OOP\* coinsurance and CC Rx plan
- No OOP\* coinsurance and EC Rx plan
- \$2,000 OOP\* coinsurance maximum and CC Rx plan
- \$2,000 OOP\* coinsurance maximum and EC Rx plan

\*Out-of-Pocket

#### \$5,000 Deductible Options

- \$30/\$50 copay and CC Rx plan
- \$30/\$50 copay and EC Rx plan
- No physician copays\*\* and CC Rx plan
- No physician copays\*\* and EC Rx plan

#### \$10,000 Deductible Options

- \$30/\$50 copay and CC Rx plan
- \$30/\$50 copay and EC Rx plan
- No physician copays\*\* and CC Rx plan
- No physician copays\*\* and EC Rx plan

#### \$25,000 Deductible Options

- \$30/\$50 copay and CC Rx plan
- \$30/\$50 copay and EC Rx plan
- No physician copays\*\* and CC Rx plan
- No physician copays\*\* and EC Rx plan

\*\*Physician visits subject to deductible.

### ▲ Blue Select Group # 601000-601007 or 602000-602007 - Grandfathered

Increase my calendar-year deductible to:

- \$1,000
- \$1,500
- \$2,500

Increase my calendar-year coinsurance maximum to:

- \$2,000

Delete the following benefit:

- SAE – Supplemental Accident Endorsement

### ▲ Blue Solution Group # 770000-770003 or 780000-780003 - Grandfathered

Increase my calendar-year deductible to:

- \$1,500
- \$3,000
- \$5,000

### ▲ Comprehensive Blue PPO Group # 790000-790007 or 700000-700007 - Grandfathered

#### Comprehensive Blue PPO II Group # 791000-798000 or 701000-708000 - Grandfathered

Increase my calendar-year deductible to:  \$1,000  \$2,500  \$5,000  \$10,000

#### Comprehensive Blue PPO Group # 300000-300007 or 390000-390007 - Non-Grandfathered

#### Comprehensive Blue PPO II Group # 391000-398000 or 301000-308000 - Non-Grandfathered

Increase my calendar-year deductible to:  \$1,000  \$2,500  \$5,000  \$10,000

### ▲ Comprehensive Blue PPO III Group # 700008-700016 or 790008-790016

Increase my calendar-year deductible to:

- \$1,500
- \$2,500
- \$5,000
- \$7,500
- \$10,000
- \$15,000
- \$20,000
- \$25,000

### ▲ Conversion Group # 902100-902140 - Grandfathered

#### Conversion Group # 302100-302140 - Non-Grandfathered

Increase my calendar-year deductible and benefit to:

- \$ 500 Deductible, 80/20% Coinsurance, \$5,000 Calendar-Year Coinsurance Maximum
- \$1,000 Deductible, 80/20% Coinsurance, \$5,000 Calendar-Year Coinsurance Maximum
- \$1,000 Deductible, 80/20% Coinsurance, No Calendar-Year Coinsurance Maximum

### ▲ HSA Blue PPO Group # 730000-730021 or 740000-740021 - Grandfathered

#### HSA Blue PPO Plus Group # 750000-750021 or 760000-760021 - Grandfathered

Increase my calendar-year deductible to:

- \$3,100 Individual/\$6,250 Family Deductible, 0% Coinsurance, No Calendar-Year Coinsurance Maximum
- \$3,100 Individual/\$6,250 Family Deductible, 80/20% Coinsurance, \$10,000 Individual/\$20,000 Calendar-Year Coinsurance Maximum
- \$6,050 Individual/\$12,100 Family Deductible, 0% Coinsurance, No Calendar-Year Coinsurance Maximum

**11 BENEFIT CHANGES (continued)**

**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.

**▲ HSA Blue PPO II Group # 711000-711005 or 722000-722005 - Grandfathered**

Increase my calendar-year deductible to:  \$2,500 Individual/\$5,000 Family Deductible  
 \$5,000 Individual/\$10,000 Family Deductible

**HSA Blue PPO II Group # 311000-311005 or 322000-322005 - Non-Grandfathered**

Increase my calendar-year deductible to:  \$2,500 Individual/\$5,000 Family Deductible  
 \$5,000 Individual/\$10,000 Family Deductible

- ▲ Uniquecare Group # 610100-611000, 620100-621000 or 650100-651000, or 660100-661000 - Grandfathered**
- Uniquecare Blue Group # 600100-600114, 600200-600214 or 600300-600311, or 600400-600410 - Grandfathered**
- Uniquecare Blue Preferred Group # 622001-622016, 633001-633016 - Grandfathered**
- Farm Bureau Flexplan Group # 809031-809046 - Grandfathered**
- Farm Bureau Flexplan Preferred Group # 808001-808027 or 808004-808028 - Grandfathered**

Increase my calendar-year deductible and benefit to:

Deductible:  \$1,000\*  \$2,500  \$5,000  \$10,000  \$25,000

\*Not available with Plan A (100% Coinsurance)

Choice of Plan:  Plan A: 100%\*\* Coinsurance  Plan B: 80/20% Coinsurance  Plan C: 50% Coinsurance  
 \*\*Coinsurance Maximum amount not applicable

Calendar-Year Coinsurance Maximum:  \$10,000  \$50,000

NOTE: Your coinsurance maximum must be greater than your deductible.

Delete the following benefit: SAE – Supplemental Accident Endorsement

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

**COMMENTS**

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

# 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.

### Important: Please Read Before Signing

2. Mail this completed authorization form to:

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

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 \_\_\_\_\_

Address \_\_\_\_\_  
Street \_\_\_\_\_ 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

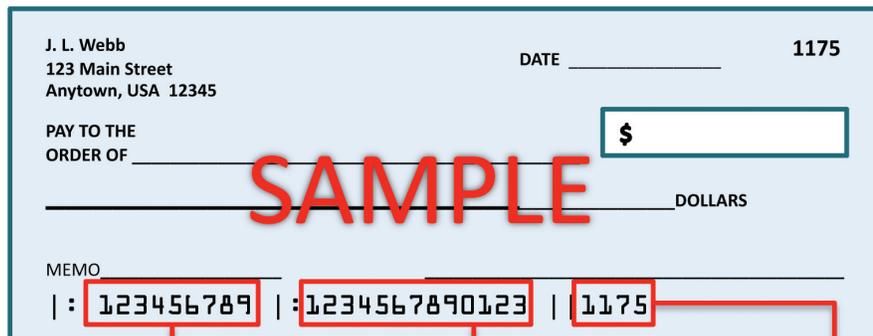
Currently, the insured's premium is drafted and the account information has changed

### Bank Account Information

Bank Name \_\_\_\_\_ Name on Account \_\_\_\_\_  
(If different than the insured)

Routing Number \_\_\_\_\_ Account Number \_\_\_\_\_

Type of Account:  Checking  Savings



Bank Routing Number

Bank Account Number

Check Number

### 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!

For Office Use Only (please do not write in this space)

ID NO.	EFFECTIVE DATE

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.



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



**Arkansas**  
**BlueCross BlueShield**  
P.O. Box 2181, Little Rock, AR 72203-2181

# *Individual/Family Health Insurance Underwriting Change Form*

**READ ALL INSTRUCTIONS BEFORE COMPLETING THIS CHANGE FORM. 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 change 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.
- 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.**

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## **\*\*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).

## INSTRUCTION SHEET

**Changes to your policy can only be made during the annual open enrollment period, unless the change is a result of 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 #. This information must be entered correctly under Section 1 in order to process your request.**

**Effective Date:** The effective date for any changes requested as a result of a qualifying life event will be the next available effective date following approval. Changes requested during the annual open enrollment period will become effective the following January (the 1st or the 15th of the month, depending on your billing date).

### SECTION 5 – 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 must be submitted 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 will also be contacted by phone to complete a Foreign National Questionnaire.

### SECTION 6 – 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)
- Death of policyholder or covered member (requires a copy of death certificate)
- Loss of Eligibility (requires a Certificate of Creditable Coverage)
- Marriage (requires a copy of the marriage certificate)

### SECTION 8 – BENEFIT CHANGES

- 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**.

*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.



**Arkansas  
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

# Underwriting Change Form For Current Policy

**Return To: Arkansas Blue Cross and Blue Shield, Attn: Individual Underwriting, P.O. Box 2181, Little Rock, AR 72203-2181 or fax to 501-378-3752**

## 1 CURRENT POLICYHOLDER INFORMATION

Member ID: \_\_\_\_\_ Group Number: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 First Name: \_\_\_\_\_ M.I.: \_\_\_\_ Last Name: \_\_\_\_\_ Social Security No.: \_\_\_\_\_  
 Residential Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

## 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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### CHANGES TO BE MADE

**Regardless of the change(s) you are requesting, you must complete sections 9-21.**

## 3 POLICY CHANGE ELIGIBILITY

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

<input type="checkbox"/> 1-Annual Open Enrollment Period			
<input type="checkbox"/> 2-Birth	Date	<input type="checkbox"/> 7-New Guardianship/Legal custody/court order to add child	Date
<input type="checkbox"/> 3-Adoption	_____	<input type="checkbox"/> 8-Loss of employer-sponsored health coverage	_____
<input type="checkbox"/> 4-Death	_____	<input type="checkbox"/> 9-Involuntary loss of other health coverage	_____
<input type="checkbox"/> 5-Marriage	_____	<input type="checkbox"/> 10-Military Leave	Date
<input type="checkbox"/> 6-Divorce or Legal Separation	_____	<input type="checkbox"/> 11-Military Reinstatement	_____
		<input type="checkbox"/> 12-Other (Give specific details & date)	_____

NOTE: If Change Form is **not** received during Open Enrollment Period, you must submit appropriate documentation with Change Form to confirm qualifying life event (i.e. copy of birth or death certificate, copy of marriage license, Certificate of Creditable Coverage from previous insurance company, guardianship/custody documentation, etc.)

## 4 POLICY APPEALS

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

## 5 U.S. CITIZENSHIP STATUS

Additional information required. Read instructions for Section 5 on the instruction sheet before completing.

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: \_\_\_\_\_

## 6 ADD SPOUSE OR DEPENDENT(S)

Read instructions for Section 6 on the instruction sheet before completing.

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.

## 7 ADD MATERNITY

AccessBlue PPO (Not an option)

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

Basic Blue PPO (Not an option)

Conversion (Not applicable)

- HSA Blue PPO
- HSA Blue PPO Plus
- HSA Blue PPO II
- UniqueCare
- UniqueCare Blue
  - \$2,000  \$3,000  \$5,000
- UniqueCare Blue Preferred
- Farm Bureau FlexPlan
- Farm Bureau FlexPlan Preferred

## 8 BENEFIT CHANGES

**▲ AccessBlue PPO** Group # 700101-700104 or 700201-700204 - Grandfathered

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

**▲ AccessBlue PPO** Group # 300101-300104 or 300201-300204 - Non-Grandfathered

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

**▲ Basic Blue PPO** Group # 710000 or 720000 - Grandfathered

Add benefit:  Physician Office Visits Rider  Prescription Drugs Rider

**▲ BlueCare PPO** Group # 600010-600016 or 600020-600026 - Grandfathered

**BlueCare PPO Plus** Group # 600030-600036 or 600040-600046 - Grandfathered

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

Decrease my calendar-year coinsurance maximum to:  \$1,000  \$2,000

**▲ Blue Choice** Group # 771000-771023 or 781000-781020 - Grandfathered

Decrease my calendar-year deductible and benefit to:

### \$500 Deductible Options

- \$1,000 OOP\* coinsurance maximum and CC Rx plan
- \$1,000 OOP\* coinsurance maximum and EC Rx plan
- \$2,000 OOP\* coinsurance maximum and CC Rx plan
- \$2,000 OOP\* coinsurance maximum and EC Rx plan

### \$1,000 Deductible Options

- \$1,000 OOP\* coinsurance maximum and CC Rx plan
- \$1,000 OOP\* coinsurance maximum and EC Rx plan
- \$2,000 OOP\* coinsurance maximum and CC Rx plan
- \$2,000 OOP\* coinsurance maximum and EC Rx plan

### \$2,500 Deductible Options

- No OOP\* coinsurance and CC Rx plan
- No OOP\* coinsurance and EC Rx plan
- \$2,000 OOP\* coinsurance maximum and CC Rx plan
- \$2,000 OOP\* coinsurance maximum and EC Rx plan

\*Out-of-Pocket

### \$5,000 Deductible Options

- \$30/\$50 copay and CC Rx plan
- \$30/\$50 copay and EC Rx plan
- No physician copays\*\* and CC Rx plan
- No physician copays\*\* and EC Rx plan

### \$10,000 Deductible Options

- \$30/\$50 copay and CC Rx plan
- \$30/\$50 copay and EC Rx plan
- No physician copays\*\* and CC Rx plan
- No physician copays\*\* and EC Rx plan

### \$25,000 Deductible Options

- \$30/\$50 copay and CC Rx plan
- \$30/\$50 copay and EC Rx plan
- No physician copays\*\* and CC Rx plan
- No physician copays\*\* and EC Rx plan

\*\*Physician visits subject to deductible.

**▲ Blue Select** Group # 601000-601007 or 602000-602007 - Grandfathered

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

Decrease my calendar-year coinsurance maximum to:  \$1,000

## 8 BENEFIT CHANGES (continued)

### ▲ Blue Solution PPO Group # 770000-770003 or 780000-780003 - Grandfathered

Decrease my calendar-year deductible to:  \$750  \$1,500  \$3,000

### ▲ Comprehensive Blue PPO Group # 790000-790007 or 700000-700007 - Grandfathered

#### Comprehensive Blue PPO II Group # 791000-798000 or 701000-708000 - Grandfathered

Decrease my calendar-year deductible to:  \$500  \$1,000  \$2,500  
 \$5,000  \$10,000

### ▲ Comprehensive Blue PPO Group # 300000-300007 or 390000-390007 - Non-Grandfathered

#### Comprehensive Blue PPO II Group # 391000-398000 or 301000-308000 - Non-Grandfathered

Decrease my calendar-year deductible to:  \$500  \$1,000  \$2,500  
 \$5,000  \$10,000

### ▲ Comprehensive Blue PPO III Group # 700008-700016 or 790008-790016

Decrease my calendar-year deductible to:  \$1,000  \$1,500  \$2,500  \$5,000  
 \$7,500  \$10,000  \$15,000  \$20,000

### ▲ Conversion Group # 902100-902140 - Grandfathered

#### Conversion Group # 302100-302140 - Non-Grandfathered

Decrease my calendar-year deductible and benefit to:

- \$ 100 Deductible, 80/20% Coinsurance, \$5,000 Calendar-Year Coinsurance Maximum
- \$ 500 Deductible, 80/20% Coinsurance, \$5,000 Calendar-Year Coinsurance Maximum
- \$1,000 Deductible, 80/20% Coinsurance, \$5,000 Calendar-Year Coinsurance Maximum

### ▲ HSA Blue PPO Group # 730000-730021 or 740000-740021 - Grandfathered

#### HSA Blue PPO Plus Group # 750000-750021 or 760000-760021 - Grandfathered

Decrease my calendar-year deductible and benefit to:

- \$1,200 Individual/\$2,400 Family Deductible, 80/20% Coinsurance, \$10,000 Individual/\$20,000 Family Coinsurance Maximum
- \$3,100 Individual/\$6,250 Family Deductible, 80/20% Coinsurance, \$10,000 Individual/\$20,000 Family Coinsurance Maximum
- \$3,100 Individual/\$6,250 Family Deductible, 0% Coinsurance, No Calendar-Year Coinsurance Maximum

### ▲ HSA Blue PPO II Group # 711000-711005 or 722000-722005 - Grandfathered

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

### ▲ HSA Blue PPO II Group # 311000-311005 or 322000-322005 - Non-Grandfathered

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

### ▲ Uniqecare Group # 610100-611000, 620100-621000 or 650100-651000, 660100-661000 - Grandfathered

#### Uniqecare Blue Group # 600100-600114, 600200-600214 or 600300-600311, 600400-600410 - Grandfathered

#### Uniqecare Blue Preferred Group # 622001-622016, 633001-633016 - Grandfathered

#### Farm Bureau Flexplan Group # 809031-809046 - Grandfathered

#### Farm Bureau Flexplan Preferred Group # 808001-808027 or 808004-808028 - Grandfathered

Decrease my calendar-year deductible and benefit to:

Deductible:  \$500\*  \$1,000\*  \$2,500  \$5,000  \$10,000

\*Not available with Plan A (100% Coinsurance)

Choice of Plan:  Plan A: 100%\*\* Coinsurance  Plan B: 80/20% Coinsurance

\*\*Coinsurance Maximum amount not applicable

Calendar-Year Coinsurance Maximum:  \$2,500  \$10,000

NOTE: Your coinsurance maximum must be greater than your deductible.

## 9 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: \_\_\_\_\_

## 10 APPLICANT(S) EMPLOYMENT INFORMATION [applicant(s) age 18 and older]

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

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

## 11 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: \_\_\_/\_\_\_/\_\_\_.
- Yes  No 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 Medicare? If "yes," please provide name(s) below:  
Name: \_\_\_\_\_  
Name: \_\_\_\_\_

## 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): \_\_\_\_\_

## 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: \_\_\_\_\_

### 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: \_\_\_\_\_

### 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

### 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

### 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

### 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: \_\_\_\_\_

### 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				

## 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 circle all conditions that apply.)**

### A. BRAIN OR NERVOUS SYSTEM DISORDERS

- Alzheimer's disease or senile dementia
- Amyotrophic lateral sclerosis (Lou Gehrig's disease)
- Cerebral palsy
- Concussion or brain injury
- Convulsions, epilepsy or seizures
- Headaches or migraines
- Meningitis
- Multiple sclerosis, muscular dystrophy or myasthenia gravis
- Neuritis
- Paralysis or palsy
- Parkinson's disease
- Polyneuritis
- Vertigo, fainting or dizziness
- Any other disorder of the brain or nervous system
- None of the above apply to any applicant(s)**

### B. CIRCULATORY

- Abnormal cholesterol/lipids
- Angina, heart attack, myocardial infarction
- Arteriosclerosis, atherosclerosis, coronary artery disease, stent placement or angioplasty
- Cerebrovascular accident (stroke), including transient ischemic attack (TIA)
- Chest pain, shortness of breath, heart murmur, palpitation of the heart, ablation, rheumatic fever
- Heart bypass surgery, pacemaker implant
- Heart or vein/artery surgery
- High blood pressure
- Hemophilia
- Valve repair/replacement
- Any other disorder of the heart, blood, blood vessels or circulatory system
- None of the above apply to any applicant(s)**

### C. DIGESTIVE

- Cirrhosis
- Crohn's disease or ulcerative colitis
- Gastric bypass surgery or other weight loss procedure
- Gastric or duodenal ulcer
- Hepatitis
- Hernia, hemorrhoids
- Irritable bowel syndrome or gastric esophageal reflux disorder (GERD)
- Pancreatitis
- Pyloric stenosis
- Any other disorder of stomach, intestines, liver, gallbladder or rectum
- None of the above apply to any applicant(s)**

### D. KIDNEY, URINARY, REPRODUCTIVE

- Abnormal pap smear
- Bladder or renal stones
- Cesarean section or miscarriage
- Dialysis
- Nephritis
- Nephrotic syndrome, renal disease or failure
- Sexually transmitted disease
- Sugar, blood or protein in urine
- Any other disorder of the kidneys or urinary tract
- Any other disorder of the male reproductive organs, including prostate
- Any other disorder of the female reproductive organs, including ovaries or breasts
- None of the above apply to any applicant(s)**

### E. RESPIRATORY

- Allergies, asthma or bronchitis
- Chronic pulmonary disease, emphysema, lung disease or respiratory syncytial virus (RSV)
- Obstructive or reactive airway disorder
- Sleep apnea, cpap, bipap or vpap
- Any other disorder of the lungs, bronchial tubes or respiratory system
- None of the above apply to any applicant(s)**

### F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS

- Anemia
- Cancer, leukemia or malignancy of any kind
- Hodgkin's or Non-Hodgkin's disease
- Melanoma, neoplasm or tumor
- Any other disorder of the lymphatic system
- Any disorder of the skin
- None of the above apply to any applicant(s)**

### G. GLANDULAR DISORDERS

- Adrenal disorders
- Diabetes, abnormal glucose
- Goiter or thyroid disease
- Any disorder of the pancreas
- None of the above apply to any applicant(s)**

### H. MUSCULOSKELETAL

- Arthritis, osteoarthritis, degenerative joint or disc disease
- Back pain and/or neck pain
- Chronic fatigue
- Connective tissue disorder
- Disease or disorder of the joints: knee(s), shoulder(s), elbow(s), wrist(s), other
- Fibromyalgia, bursitis or tendonitis

### MUSCULOSKELETAL (cont.)

- Fracture(s) or broken bone(s)  
Exposed bone  Yes  No
- Gout
- Lupus, systemic
- Temporomandibular joint disorder (TMJ/TMD) or craniomandibular disorder
- Any other disorder of the muscles, bones or joints to include chiropractic care
- None of the above apply to any applicant(s)**

### I. EARS/EYES/NOSE/THROAT

- Cataracts or glaucoma
- Meniere's disease
- Nasal septal defect
- Sinusitis, tonsillitis or otitis media
- Any other disorder of the eyes, ears, nose, throat or esophagus
- None of the above apply to any applicant(s)**

### J. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE

- Anxiety, insomnia, sleep disorder, depression, emotional problems or nervous disorder
- Attempted suicide
- Counseling or psychiatric treatment (in-patient or out-patient)
- Bipolar disorder, obsessive compulsive disorder or developmental disorder
- Eating disorder
- Any other mental, emotional disorder or situation, including ADD/ADHD
- None of the above apply to any applicant(s)**

### K. OTHER

- Current patient in a hospital or nursing home
- Pending Surgery Surgery Date: \_\_/\_\_/\_\_
- Sarcoidosis
- Breast implants  
 Saline  Silicone Surgery Date: \_\_/\_\_/\_\_
- Any other implant(s), prosthetic device(s), internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents)
- Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder or HIV
- Transplant recipient
- Any injury, deformity, incapacitation, disease or condition not listed elsewhere
- None of the above apply to any applicant(s)**

## 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	Date of Last Visit	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					

## 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. \*\*Use "Comments" section on Page 8 if more room is needed for details.

**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) Any members age 19 or older added to my policy will be subject to a 12-month pre-existing waiting period. This means conditions existing prior to the member's effective date of this policy will not be covered until his/her coverage has been in effect for 12 months. (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 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 <b>(required if policyholder is age 19 or older)</b> OR Parent/Guardian <b>(if policy for a minor)</b>	(Please Print) <b>X</b>	Date Signed
	(Please Sign) <b>X</b>	
Spouse <b>(required if applying)</b>	<b>X</b>	Date Signed
Dependent age 18 or older <b>(required if applying)</b>	<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 primary applicant or the parent/guardian indicated in Section 2, the **custodial parent's** signature is also required.

Custodial Parent's Name <b>(please print)</b>	<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

**This section to be completed by sales representative**

To the best of your knowledge, will the coverage applied for replace or change any existing hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant?  Yes  No

Sales Rep License No. <b>(required)</b>	Sales Representative's Name (Please Print) <b>X</b>	Telephone No.
Agency Federal Tax ID No. <b>(If applicable)</b>	Sales Representative's Signature <b>X</b>	Date Signed

**COMMENTS**

	<b>OFFICE USE ONLY</b>
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**THIS APPLICATION IS VALID FOR 90 DAYS ONLY WHEN COMPLETED AND SIGNED.**



# Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

## IMPORTANT:

We cannot process your application without this completed form.

### 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 health care 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 health care item or service in relation to the health care 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).

<b>Applicants age 18 and older</b>	<b>This authorization must be signed by 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	____/____/____



**Arkansas**  
**BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

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

# Newborn/Adopted Child Change Form

This form should be completed if you are requesting to add to your policy a newborn within 90 days of birth or adopted child within 60 days of filing the adoption petition. Documentation is required to add an adopted child(ren) and the appropriate documentation such as a copy of adoption papers or other court papers must accompany this form, in order to support this change. If you are requesting to add a newborn or adopted child outside the above-referenced time limits, you will need to complete an **Underwriting Change Form**. To request an **Underwriting Change Form**, call **1-800-238-8379**.

**Medical underwriting may apply to the addition of a newborn/adopted child.** Please refer to your policy for more information.

**Please Note: Do not submit this change form prior to a newborn's date of birth or prior to the filing of the adoption petition.**

## BEFORE COMPLETING THIS CHANGE FORM, PLEASE READ THE FOLLOWING INSTRUCTIONS:

- This form is a legal document. It is very important that you provide **all** requested information and that it is accurate and legible.
- Please ensure that all required parties sign and date the form.
- This form must be completed in dark blue or black ink.
- If you make a mistake, please mark through the incorrect information, initial it, date it and then provide the correct information.
- **Do not use liquid paper, correction tape or "white out" to correct any mistakes you make on this application.**
- Any attached sheets must be signed and dated.
- **We strongly encourage you to make a photocopy of this completed form for your records.**

## \*\*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)



# IMPORTANT:

We cannot process your application without this completed form.

## 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 health care 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 health care item or service in relation to the health care 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).

Name of Newborn/Adopted Child(ren) (Please Print)

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\_\_\_\_\_  
Parent/Legal Guardian's Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date



# Newborn/Adopted Child Change Form

Return To: Arkansas Blue Cross and Blue Shield, Attn: Individual Underwriting, P.O. Box 2181, Little Rock, AR 72203-2181

## 1 POLICYHOLDER INFORMATION

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

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

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

## 2 CONTACT INFORMATION

Primary Phone Number

Alternate Phone Number

E-Mail Address

( )

( )

## 3 NEWBORN OR ADOPTED CHILD(REN) INFORMATION

Indicate below the name of the dependent(s) you want added to this policy.

First Name	M.I.	Last Name	Suffix	Sex	Date of Birth	Adoption Petition Date	Social Security No.	Newborn or Adopted

Does the proposed child(ren) reside with the policyholder? \_\_\_\_ Yes \_\_\_\_ No

If "no," please provide the following:

Name of Parent/Guardian child(ren) resides with: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone Number: (\_\_\_\_) \_\_\_\_\_ Alternate Phone Number: (\_\_\_\_) \_\_\_\_\_

E-Mail Address \_\_\_\_\_

**PLEASE READ BEFORE SIGNING**

I UNDERSTAND: (1) 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. (2) 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 intentional misrepresentations of material fact or fraud. (3) 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. (4) 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 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 of Policyholder	<b>X</b>	Date Signed
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**FOR HOME OFFICE ENDORSEMENTS**

**Important Note:** If the addition of your newborn or adopted child requires medical underwriting, you will receive a telephone call from our Underwriting Division. In such instances, your newborn or adopted child will be added to your policy only upon approval by our Underwriting Division; and the effective date of coverage will be subsequent to the approval date.

**OFFICE USE ONLY**



**Arkansas  
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

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

SERFF Tracking Number: ARBB-128378859 State: Arkansas  
 Filing Company: Arkansas Blue Cross and Blue Shield State Tracking Number:  
 Company Tracking Number: U-65 APP AG R07-12  
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider  
 (PPO)  
 Product Name: Applications  
 Project Name/Number: Under 65 Applications/U-65 APP AG, U-65 APP DR, U-65 APP LB AG

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Flesch Certification	Approved-Closed	05/21/2012
<b>Bypass Reason:</b>	Not required.		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Application	Approved-Closed	05/21/2012
<b>Comments:</b>	Already attached.		

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Health - Actuarial Justification	Approved-Closed	05/21/2012
<b>Bypass Reason:</b>	Not required.		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Outline of Coverage	Approved-Closed	05/21/2012
<b>Bypass Reason:</b>	Not required.		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	PPACA Uniform Compliance Summary	Approved-Closed	05/21/2012
<b>Bypass Reason:</b>	Not PPACA related.		
<b>Comments:</b>			