

**State:** Arkansas **Filing Company:** Arkansas Blue Cross and Blue Shield  
**TOI/Sub-TOI:** H21 Health - Other/H21.000 Health - Other  
**Product Name:** Questionnaire  
**Project Name/Number:** Questionnaire Application/FNQ (R04/12)

## Filing at a Glance

Company: Arkansas Blue Cross and Blue Shield  
 Product Name: Questionnaire  
 State: Arkansas  
 TOI: H21 Health - Other  
 Sub-TOI: H21.000 Health - Other  
 Filing Type: Form  
 Date Submitted: 07/26/2012  
 SERFF Tr Num: ARBB-128601273  
 SERFF Status: Closed-Approved-Closed  
 State Tr Num:  
 State Status: Approved-Closed  
 Co Tr Num: FNQ (R04/12)  
 Implementation: On Approval  
 Date Requested:  
 Author(s): zSERFFStaff zIndustrySupportCL, Christi Kittler, Yvonne McNaughton, Frank Sewall, Rita Thatcher, Evelyn Laney  
 Reviewer(s): Donna Lambert (primary)  
 Disposition Date: 08/27/2012  
 Disposition Status: Approved-Closed  
 Implementation Date:  
 State Filing Description:

State: Arkansas  
 TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other  
 Product Name: Questionnaire  
 Project Name/Number: Questionnaire Application/FNQ (R04/12)

Filing Company: Arkansas Blue Cross and Blue Shield

**General Information**

Project Name: Questionnaire Application Status of Filing in Domicile: Pending  
 Project Number: FNQ (R04/12) Date Approved in Domicile:  
 Requested Filing Mode: Review & Approval Domicile Status Comments: Arkansas is state of domicile.  
 Explanation for Combination/Other: Market Type: Individual  
 Submission Type: New Submission Individual Market Type: Individual  
 Overall Rate Impact: Filing Status Changed: 08/27/2012  
 State Status Changed: 08/27/2012  
 Deemer Date: Created By: Evelyn Laney  
 Submitted By: Evelyn Laney Corresponding Filing Tracking Number:  
 PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

Attached please find form FNQ (R04/12) for your review and approval if indicated.  
 This questionnaire is specific to those individuals who apply for under 65 comprehensive products who are not U.S. citizens.  
 I certify that the submission meets the provisions of Arkansas Insurance Department Rule & Regulation 19.  
 Please feel free to contact me at 378-2165 with any questions you may have.

**Company and Contact**

**Filing Contact Information**

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

**Filing Company Information**

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

**Filing Fees**

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

Company	Amount	Date Processed	Transaction #
Arkansas Blue Cross and Blue Shield	\$50.00	07/26/2012	61215866

**SERFF Tracking #:**

ARBB-128601273

**State Tracking #:****Company Tracking #:**

FNQ (R04/12)

**State:**

Arkansas

**Filing Company:**

Arkansas Blue Cross and Blue Shield

**TOI/Sub-TOI:**

H21 Health - Other/H21.000 Health - Other

**Product Name:**

Questionnaire

**Project Name/Number:**

Questionnaire Application/FNQ (R04/12)

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Donna Lambert	08/27/2012	08/27/2012

### Objection Letters and Response Letters

#### Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	07/26/2012	07/26/2012

#### Response Letters

Responded By	Created On	Date Submitted
Christi Kittler	08/27/2012	08/27/2012

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Objection letter of 7/25/12	Note To Filer	Rosalind Minor	08/20/2012	08/20/2012

**SERFF Tracking #:**

ARBB-128601273

**State Tracking #:****Company Tracking #:**

FNQ (R04/12)

**State:**

Arkansas

**Filing Company:**

Arkansas Blue Cross and Blue Shield

**TOI/Sub-TOI:**

H21 Health - Other/H21.000 Health - Other

**Product Name:**

Questionnaire

**Project Name/Number:**

Questionnaire Application/FNQ (R04/12)

## Disposition

Disposition Date: 08/27/2012

Implementation Date:

Status: Approved-Closed

HHS Status: Not Reported

State Review: Not Reviewed

Comment:

Rate data does NOT apply to filing.

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

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**State:** Arkansas **Filing Company:** Arkansas Blue Cross and Blue Shield  
**TOI/Sub-TOI:** H21 Health - Other/H21.000 Health - Other  
**Product Name:** Questionnaire  
**Project Name/Number:** Questionnaire Application/FNQ (R04/12)

## Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	07/26/2012
Submitted Date	07/26/2012
Respond By Date	08/26/2012

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Dear Evelyn Laney,

**Introduction:**

*This will acknowledge receipt of the captioned filing.*

**Objection 1**

*- Application, FNQ (R04/12) (Form)*

*Comments:*

*Will this form be used in connection with another application that contains a Fraud Statement or will this be a stand-alone form? If it is used as a stand-alone, please add the Fraud Statement.*

**Conclusion:**

*A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.*

*Please feel free to contact me if you have questions.*

*Sincerely,*

*Rosalind Minor*

SERFF Tracking #:

ARBB-128601273

State Tracking #:

Company Tracking #:

FNQ (R04/12)

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State:

Arkansas

Filing Company:

Arkansas Blue Cross and Blue Shield

TOI/Sub-TOI:

H21 Health - Other/H21.000 Health - Other

Product Name:

Questionnaire

Project Name/Number:

Questionnaire Application/FNQ (R04/12)

## Response Letter

Response Letter Status	Submitted to State
Response Letter Date	08/27/2012
Submitted Date	08/27/2012

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*Dear Donna Lambert,*

**Introduction:**

*Hi Donna -*

**Response 1**

**Comments:**

*Please see the revised form.*

**Related Objection 1**

*Applies To:*

*- Application, FNQ (R04/12) (Form)*

*Comments:*

*Will this form be used in connection with another application that contains a Fraud Statement or will this be a stand-alone form? If it is used as a stand-alone, please add the Fraud Statement.*

**Changed Items:**

*No Supporting Documents changed.*

SERFF Tracking #:

ARBB-128601273

State Tracking #:

Company Tracking #:

FNQ (R04/12)

State: Arkansas  
TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other  
Product Name: Questionnaire  
Project Name/Number: Questionnaire Application/FNQ (R04/12)

Filing Company: Arkansas Blue Cross and Blue Shield

Form Schedule Item Changes							
Item No.	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments	Submitted
1	FNQ (R08/12)	AEF	Applicat ion	Initial		FOREIGNNATION ALQUESTrev2.pdf	Date Submitted: 08/27/2012 By: Christi Kittler
<i>Previous Version</i>							
1	FNQ (R04/12)	AEF	Applicat ion	Initial		FOREIGNNATION ALQUESTrevR04- 12).pdf	Date Submitted: 08/27/2012 By: Christi Kittler

No Rate/Rule Schedule items changed.

**Conclusion:**

Thanks so much!

Sincerely,

Christi Kittler

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**State:** Arkansas **Filing Company:** Arkansas Blue Cross and Blue Shield  
**TOI/Sub-TOI:** H21 Health - Other/H21.000 Health - Other  
**Product Name:** Questionnaire  
**Project Name/Number:** Questionnaire Application/FNQ (R04/12)

## Note To Filer

**Created By:**

Rosalind Minor on 08/20/2012 09:06 AM

**Last Edited By:**

Donna Lambert

**Submitted On:**

08/27/2012 12:15 PM

**Subject:**

Objection letter of 7/25/12

**Comments:**

As of this date, we have not received a response to our objection letter of 7/25/12. Do you still want me to leave the file open or do you want me to withdraw the filing?

Thank you for your cooperation.

SERFF Tracking #:

ARBB-128601273

State Tracking #:

Company Tracking #:

FNQ (R04/12)

State: Arkansas  
 TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other  
 Product Name: Questionnaire  
 Project Name/Number: Questionnaire Application/FNQ (R04/12)

Filing Company: Arkansas Blue Cross and Blue Shield

## Form Schedule

Lead Form Number: FNQ (R04/12)							
Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
1	Approved 08/27/2012	FNQ (R08/12)	AEF	Application	Initial:		FOREIGNNATIONALQU ESTrev2.pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages



# FOREIGN NATIONAL QUESTIONNAIRE

Return To: Arkansas Blue Cross and Blue Shield, ATTN: Individual Underwriting Foreign National Questionnaire,  
P.O. Box 2181, Little Rock, AR 72203-2181 or Fax to: 501-399-3920.

All applicable sections below must be completed for your application for health insurance to be processed. Attach an additional sheet if more space is needed. A medical report for each person to be covered may be requested. To be considered for possible eligibility, the documentation listed under Basic Requirements below is required of **each individual** seeking coverage on an individual policy with Arkansas Blue Cross and Blue Shield.

## BASIC REQUIREMENTS

- A Social Security number (for all individuals over age 1)
- An active permanent visa or permanent green card good for at least a year into the future from the time of applying for coverage
- A copy of medical records from each individual's United States primary care physician
- Evidence each individual applying for coverage has been in the United States for a minimum of 12 consecutive months
- Submission to a paramedical examination to include a collection of blood and urine for laboratory analysis (required for each adult applicant age 19 and older)

1. APPLICANT INFORMATION											
Last Name		First Name			M.I.		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth Mo. ____ Day ____ Yr. ____		
Current U.S. Resident Address – Street				Country of Citizenship			How long have you lived at this address?				
City				State		Zip Code		Daytime Phone Number			
Previous U.S. Address (if applicable) – Street						How long did you live at this address?					
City				State		Zip Code					
2. SPOUSE AND DEPENDENT INFORMATION											
Dependents First Name		M.I.	Last Name		Date of Birth Mo. Day Yr.		Relationship (Spouse, Son, Daughter, etc.)		Live with Applicant?	U.S. Citizen	If No, Country of Citizenship
Spouse					/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 1					/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 2					/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 3					/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 4					/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 5					/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. IMMIGRATION STATUS											
First Name		M.I.	Last Name		Date of Entry Into USA Mo. Day Yr.		Social Security Number	Type of Permanent Visa or Permanent Green Card		Issue Date Mo. Day Yr.	Expiration Date Mo. Day Yr.
Applicant					/ /			USCIS Category _____ Registration No. _____		/ /	/ /
Spouse					/ /			USCIS Category _____ Registration No. _____		/ /	/ /

**3. IMMIGRATION STATUS (continued)**

First Name	M.I.	Last Name	Date of Entry Into USA			Social Security Number	Type of Permanent Visa or Permanent Green Card	Issue Date			Expiration Date			
			Mo.	Day	Yr.			Mo.	Day	Yr.	Mo.	Day	Yr.	
Dependent 1			/ /						USCIS Category			/ /		
									Registration No.					
Dependent 2			/ /						USCIS Category			/ /		
									Registration No.					
Dependent 3			/ /						USCIS Category			/ /		
									Registration No.					
Dependent 4			/ /						USCIS Category			/ /		
									Registration No.					
Dependent 5			/ /						USCIS Category			/ /		
									Registration No.					

Planned travel outside U.S.A. (indicate person(s) traveling): \_\_\_\_\_  
 \_\_\_\_\_ Where \_\_\_\_\_ Days Per Year \_\_\_\_\_

What is the reason for being in the United States? \_\_\_\_\_ How long do you plan to be in the U.S.A.? \_\_\_\_\_

**4. PRIMARY CARE PHYSICIAN INFORMATION**

First Name	M.I.	Last Name	Primary Care Physician Name	Primary Care Physician Address
Applicant				
Spouse				
Dependent 1				
Dependent 2				
Dependent 3				
Dependent 4				
Dependent 5				

**5. EMPLOYER / SCHOOL INFORMATION**

**APPLICANT**

Name of Current United States Employer or School Attending: \_\_\_\_\_

Address Street City State Zip Code

How long have you worked for this employer or attended this school? \_\_\_\_\_ What is your occupation? \_\_\_\_\_

Name of Previous U.S.A. Employer or School Attended (if applicable): \_\_\_\_\_

Address Street City State Zip Code

How long did you work for this employer or attend this school? \_\_\_\_\_ What was your occupation? \_\_\_\_\_

**5. EMPLOYER / SCHOOL INFORMATION (continued)****SPOUSE**

Name of Current United States Employer or School Attending:

Address	Street	City	State	Zip Code
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How long have you worked for this employer or attended this school?	What is your occupation?
---------------------------------------------------------------------	--------------------------

Name of Previous U.S.A. Employer or School Attended (if applicable):

Address	Street	City	State	Zip Code
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How long did you work for this employer or attend this school?	What was your occupation?
----------------------------------------------------------------	---------------------------

**DEPENDENT 1**

Name of Current United States Employer or School Attending:

Address	Street	City	State	Zip Code
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How long have you worked for this employer or attended this school?	What is your occupation?
---------------------------------------------------------------------	--------------------------

Name of Previous U.S.A. Employer or School Attended (if applicable):

Address	Street	City	State	Zip Code
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How long did you work for this employer or attend this school?	What was your occupation?
----------------------------------------------------------------	---------------------------

**DEPENDENT 2**

Name of Current United States Employer or School Attending:

Address	Street	City	State	Zip Code
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How long have you worked for this employer or attended this school?	What is your occupation?
---------------------------------------------------------------------	--------------------------

Name of Previous U.S.A. Employer or School Attended (if applicable):

Address	Street	City	State	Zip Code
---------	--------	------	-------	----------

How long did you work for this employer or attend this school?	What was your occupation?
----------------------------------------------------------------	---------------------------

**DEPENDENT 3**

Name of Current United States Employer or School Attending:

Address	Street	City	State	Zip Code
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How long have you worked for this employer or attended this school?	What is your occupation?
---------------------------------------------------------------------	--------------------------

Name of Previous U.S.A. Employer or School Attended (if applicable):

Address	Street	City	State	Zip Code
---------	--------	------	-------	----------

How long did you work for this employer or attend this school?	What was your occupation?
----------------------------------------------------------------	---------------------------



**SERFF Tracking #:**

ARBB-128601273

**State Tracking #:****Company Tracking #:**

FNQ (R04/12)

**State:**

Arkansas

**Filing Company:**

Arkansas Blue Cross and Blue Shield

**TOI/Sub-TOI:**

H21 Health - Other/H21.000 Health - Other

**Product Name:**

Questionnaire

**Project Name/Number:**

Questionnaire Application/FNQ (R04/12)

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
Bypassed - Item:	Flesch Certification	Approved	08/27/2012
Bypass Reason:	Not required.		
Comments:			

		<b>Item Status:</b>	<b>Status Date:</b>
Bypassed - Item:	Application	Approved	08/27/2012
Bypass Reason:	Already attached.		
Comments:			

		<b>Item Status:</b>	<b>Status Date:</b>
Bypassed - Item:	Health - Actuarial Justification	Approved	08/27/2012
Bypass Reason:	Not required.		
Comments:			

		<b>Item Status:</b>	<b>Status Date:</b>
Bypassed - Item:	Outline of Coverage	Approved	08/27/2012
Bypass Reason:	Not required.		
Comments:			

		<b>Item Status:</b>	<b>Status Date:</b>
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved	08/27/2012
Bypass Reason:	Not PPACA related.		
Comments:			

**SERFF Tracking #:**

ARBB-128601273

**State Tracking #:****Company Tracking #:**

FNQ (R04/12)

**State:**

Arkansas

**Filing Company:**

Arkansas Blue Cross and Blue Shield

**TOI/Sub-TOI:**

H21 Health - Other/H21.000 Health - Other

**Product Name:**

Questionnaire

**Project Name/Number:**

Questionnaire Application/FNQ (R04/12)

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/26/2012	Form	Application	08/27/2012	FOREIGNNATIONALQUESTrevR04-12).pdf (Superseded)



# FOREIGN NATIONAL QUESTIONNAIRE

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P.O. Box 2181, Little Rock, AR 72203-2181 or Fax to: 501-399-3920.

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## BASIC REQUIREMENTS

- A Social Security number (for all individuals over age 1)
- An active permanent visa or permanent green card good for at least a year into the future from the time of applying for coverage
- A copy of medical records from each individual's United States primary care physician
- Evidence each individual applying for coverage has been in the United States for a minimum of 12 consecutive months
- Submission to a paramedical examination to include a collection of blood and urine for laboratory analysis (required for each adult applicant age 19 and older)

1. APPLICANT INFORMATION											
Last Name		First Name			M.I.		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth Mo. ____ Day ____ Yr. ____		
Current U.S. Resident Address – Street				Country of Citizenship			How long have you lived at this address?				
City				State		Zip Code		Daytime Phone Number			
Previous U.S. Address (if applicable) – Street							How long did you live at this address?				
City				State		Zip Code					
2. SPOUSE AND DEPENDENT INFORMATION											
Dependents First Name		M.I.	Last Name		Date of Birth Mo. Day Yr.		Relationship (Spouse, Son, Daughter, etc.)		Live with Applicant?	U.S. Citizen	If No, Country of Citizenship
Spouse					/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 1					/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 2					/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 3					/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 4					/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 5					/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. IMMIGRATION STATUS											
First Name		M.I.	Last Name		Date of Entry Into USA Mo. Day Yr.		Social Security Number	Type of Permanent Visa or Permanent Green Card		Issue Date Mo. Day Yr.	Expiration Date Mo. Day Yr.
Applicant					/ /			USCIS Category _____ Registration No. _____		/ /	/ /
Spouse					/ /			USCIS Category _____ Registration No. _____		/ /	/ /

**3. IMMIGRATION STATUS (continued)**

First Name	M.I.	Last Name	Date of Entry Into USA			Social Security Number	Type of Permanent Visa or Permanent Green Card	Issue Date			Expiration Date			
			Mo.	Day	Yr.			Mo.	Day	Yr.	Mo.	Day	Yr.	
Dependent 1			/ /						USCIS Category			/ /		
									Registration No.					
Dependent 2			/ /						USCIS Category			/ /		
									Registration No.					
Dependent 3			/ /						USCIS Category			/ /		
									Registration No.					
Dependent 4			/ /						USCIS Category			/ /		
									Registration No.					
Dependent 5			/ /						USCIS Category			/ /		
									Registration No.					

Planned travel outside U.S.A. (indicate person(s) traveling): \_\_\_\_\_  
 \_\_\_\_\_ Where \_\_\_\_\_ Days Per Year \_\_\_\_\_

What is the reason for being in the United States? \_\_\_\_\_ How long do you plan to be in the U.S.A.? \_\_\_\_\_

**4. PRIMARY CARE PHYSICIAN INFORMATION**

First Name	M.I.	Last Name	Primary Care Physician Name	Primary Care Physician Address
Applicant				
Spouse				
Dependent 1				
Dependent 2				
Dependent 3				
Dependent 4				
Dependent 5				

**5. EMPLOYER / SCHOOL INFORMATION****APPLICANT**

Name of Current United States Employer or School Attending: \_\_\_\_\_

Address Street City State Zip Code

How long have you worked for this employer or attended this school? \_\_\_\_\_ What is your occupation? \_\_\_\_\_

Name of Previous U.S.A. Employer or School Attended (if applicable): \_\_\_\_\_

Address Street City State Zip Code

How long did you work for this employer or attend this school? \_\_\_\_\_ What was your occupation? \_\_\_\_\_

**5. EMPLOYER / SCHOOL INFORMATION (continued)**

**SPOUSE**

Name of Current United States Employer or School Attending:

Address	Street	City	State	Zip Code
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How long have you worked for this employer or attended this school?      What is your occupation?

Name of Previous U.S.A. Employer or School Attended (if applicable):

Address	Street	City	State	Zip Code
---------	--------	------	-------	----------

How long did you work for this employer or attend this school?      What was your occupation?

**DEPENDENT 1**

Name of Current United States Employer or School Attending:

Address	Street	City	State	Zip Code
---------	--------	------	-------	----------

How long have you worked for this employer or attended this school?      What is your occupation?

Name of Previous U.S.A. Employer or School Attended (if applicable):

Address	Street	City	State	Zip Code
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How long did you work for this employer or attend this school?      What was your occupation?

**DEPENDENT 2**

Name of Current United States Employer or School Attending:

Address	Street	City	State	Zip Code
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How long have you worked for this employer or attended this school?      What is your occupation?

Name of Previous U.S.A. Employer or School Attended (if applicable):

Address	Street	City	State	Zip Code
---------	--------	------	-------	----------

How long did you work for this employer or attend this school?      What was your occupation?

**DEPENDENT 3**

Name of Current United States Employer or School Attending:

Address	Street	City	State	Zip Code
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How long have you worked for this employer or attended this school?      What is your occupation?

Name of Previous U.S.A. Employer or School Attended (if applicable):

Address	Street	City	State	Zip Code
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How long did you work for this employer or attend this school?      What was your occupation?

**5. EMPLOYER / SCHOOL INFORMATION (continued)**

**DEPENDENT 4**

Name of Current United States Employer or School Attending:

Address	Street	City	State	Zip Code
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How long have you worked for this employer or attended this school?	What is your occupation?
---------------------------------------------------------------------	--------------------------

Name of Previous U.S.A. Employer or School Attended (if applicable):

Address	Street	City	State	Zip Code
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How long did you work for this employer or attend this school?	What was your occupation?
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**DEPENDENT 5**

Name of Current United States Employer or School Attending:

Address	Street	City	State	Zip Code
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How long have you worked for this employer or attended this school?	What is your occupation?
---------------------------------------------------------------------	--------------------------

Name of Previous U.S.A. Employer or School Attended (if applicable):

Address	Street	City	State	Zip Code
---------	--------	------	-------	----------

How long did you work for this employer or attend this school?	What was your occupation?
----------------------------------------------------------------	---------------------------

**6. CERTIFICATION**

I certify that the statements and answers to all of the above questions are true and complete to the best of my knowledge. I acknowledge that any incorrect information given on this questionnaire can result in rescission or termination of my coverage and denial of claims. I agree that this questionnaire shall become a part of my application and any contract of insurance issued by Arkansas Blue Cross and Blue Shield.

Name of Applicant	Signature of Applicant	Date
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**Arkansas  
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