

State: Arkansas **Filing Company:** Arkansas Blue Cross and Blue Shield
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Revised Application
Project Name/Number: Application/UndChg Form (R10/12), U-65 CF NonUnd (R10/12)

Filing at a Glance

Company: Arkansas Blue Cross and Blue Shield
 Product Name: Revised Application
 State: Arkansas
 TOI: H16I Individual Health - Major Medical
 Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)
 Filing Type: Form
 Date Submitted: 08/24/2012
 SERFF Tr Num: ARBB-128657133
 SERFF Status: Closed-Approved-Closed
 State Tr Num:
 State Status: Approved-Closed
 Co Tr Num: UNDCHG FORM (R10/12), U-65 CF NONUND (R10/12)
 Implementation: On Approval
 Date Requested:
 Author(s): zSERFFStaff zIndustrySupportCL, Christi Kittler, Yvonne McNaughton, Frank Sewall, Rita Thatcher, Evelyn Laney
 Reviewer(s): Rosalind Minor (primary)
 Disposition Date: 09/10/2012
 Disposition Status: Approved-Closed
 Implementation Date:
 State Filing Description:

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General Information

Project Name: Application	Status of Filing in Domicile: Pending
Project Number: UndChg Form (R10/12), U-65 CF NonUnd (R10/12)	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: 09/10/2012
	State Status Changed: 09/10/2012
Deemer Date:	Created By: Evelyn Laney
Submitted By: Christi Kittler	Corresponding Filing Tracking Number:
	PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

Attached please find forms UndChg Form, U-65 CF NonUnd R10/12 for your review and approval if indicated. In these revised forms, we have changed the HSA Blue PPO and HSA Blue PPO Plus deductibles as a result of the 2013 COLA changes, as required.

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

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:	\$100.00
Retaliatory?	No
Fee Explanation:	\$50.00 per form
Per Company:	No

SERFF Tracking #: ARBB-128657133 State Tracking #:

Company Tracking #: UNDCHG FORM (R10/12), U-65
CF NONUND (R1...

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Company	Amount	Date Processed	Transaction #
Arkansas Blue Cross and Blue Shield	\$100.00	08/24/2012	61976492

State: Arkansas Filing Company: Arkansas Blue Cross and Blue Shield
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/10/2012	09/10/2012
Approved-Closed	Rosalind Minor	09/07/2012	09/07/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application	Christi Kittler	09/10/2012	09/10/2012

State: Arkansas **Filing Company:** Arkansas Blue Cross and Blue Shield
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Disposition

Disposition Date: 09/10/2012

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

This submission was re-opened at your request in order to replace a form.

Form UndChag Form (R10/12) will maintain its approval date of 9/7/10. The replaced form is approved effective on this date.

Rate data does NOT apply to filing.

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 (revised)	Application	Approved-Closed	Yes
Form	Application	Replaced	Yes

SERFF Tracking #:

ARBB-128657133

State Tracking #:**Company Tracking #:**UNDCHG FORM (R10/12), U-65 CF
NONUND (R1...**State:**

Arkansas

Filing Company:

Arkansas Blue Cross and Blue Shield

TOI/Sub-TOI:

H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name:

Revised Application

Project Name/Number:

Application/UndChg Form (R10/12), U-65 CF NonUnd (R10/12)

Disposition

Disposition Date: 09/07/2012

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

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 (revised)	Application	Approved-Closed	Yes
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SERFF Tracking #:

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State Tracking #:

Company Tracking #:

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NONUND (R1...

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Arkansas

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Amendment Letter

Submitted Date: 09/10/2012

Comments:

As discussed in my email, I attached the same form twice instead of the new CF.

Thanks so much!

Christi

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
U-65 CF NonUnd (R10/12)	Application/Enrollment Form	Application	Revised		U-65 CF NonUnd (R07/12)	U-65 CF NonUnd (R10/12)		U-65_CF_NonUnd_(R010-12).pdf

State: Arkansas

Filing Company:

Arkansas Blue Cross and Blue Shield

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Form Schedule

Lead Form Number: UndChg Form (R10/12),

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 09/07/2012	UndChg Form (R10/12)	AEF	Application	Revised: Replaced Form #: UndChg Form (R10/12) Previous Filing #: UndChg Form (R07/12)		UndChg_Form_(R10- 12).pdf
2	Approved-Closed 09/10/2012	U-65 CF NonUnd (R10/12)	AEF	Application	Revised: Replaced Form #: U-65 CF NonUnd (R10/12) Previous Filing #: U-65 CF NonUnd (R07/12)		U- 65_CF_NonUnd_(R010- 12).pdf

Form Type Legend:

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

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.**

****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.

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
---------------------------------	-----------------------------------	----------------	--

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"/> 6-Divorce or Legal Separation | _____ | <input type="checkbox"/> 10-Military Leave | Date |
| | | <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:

- \$1,250 Individual/\$2,500 Family Deductible, 80/20% Coinsurance, \$10,000 Individual/\$20,000 Family Coinsurance Maximum
- \$3,250 Individual/\$6,450 Family Deductible, 80/20% Coinsurance, \$10,000 Individual/\$20,000 Family Coinsurance Maximum
- \$3,250 Individual/\$6,450 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 (required if policyholder is age 19 or older) OR Parent/Guardian (if policy for a minor)	(Please Print) X	Date Signed
	(Please Sign) X	
Spouse (required if applying)	X	Date Signed
Dependent age 18 or older (required if applying)	X	Date Signed

CUSTODIAL PARENT SECTION

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

Custodial Parent's Name (please print)	X	Telephone No.
Custodial Parent's Address	Street or PO Box	City State Zip
Custodial Parent's Signature	X	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. (required)	Sales Representative's Name (Please Print) X	Telephone No.
Agency Federal Tax ID No. (If applicable)	Sales Representative's Signature X	Date Signed

COMMENTS

	OFFICE USE ONLY
--	------------------------

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).

Applicants age 18 and older	This authorization must be signed by each applicant age 18 or older.		
	Print Name(s)	Signature	Date
	_____	_____	____/____/____
	_____	_____	____/____/____
	_____	_____	____/____/____
	_____	_____	____/____/____
	_____	_____	____/____/____
Applicants under age 18	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



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.

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 1st or 15th 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: 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: _____

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
---------------------------------	-----------------------------------	----------------	--

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 | Date | _____ | <input type="checkbox"/> 7-New Guardianship/Legal custody/court order to add child | Date | _____ | <input type="checkbox"/> 10-Military Leave | Date | _____ |
| <input type="checkbox"/> 2-Birth | _____ | <input type="checkbox"/> 8-Loss of employer-sponsored health coverage | _____ | <input type="checkbox"/> 11-Military Reinstatement | _____ | <input type="checkbox"/> 12-Other (Give specific details & date) | _____ | _____ |
| <input type="checkbox"/> 3-Adoption | _____ | <input type="checkbox"/> 9-Involuntary loss of other health coverage | _____ | _____ | _____ | _____ | _____ | _____ |
| <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.

<p>▲ AccessBlue PPO Group # 700101-700104 or 700201-700204 - Grandfathered Increase my calendar-year deductible to: <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500</p> <p>▲ AccessBlue PPO Group # 300101-300104 or 300201-300204 - Non-Grandfathered Increase my calendar-year deductible to: <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500</p>

<p>▲ Basic Blue PPO Group # 710000 or 720000 - Grandfathered Delete the following benefit: <input type="checkbox"/> Physician Office Visits Rider <input type="checkbox"/> Prescription Drugs Rider</p>
--

<p>▲ 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: <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500* Increase my calendar-year coinsurance maximum to: <input type="checkbox"/> \$2,000 *\$2,500 has no coinsurance maximum</p>

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:

- \$3,250 Individual/\$6,450 Family Deductible, 0% Coinsurance, No Calendar-Year Coinsurance Maximum
- \$3,250 Individual/\$6,450 Family Deductible, 80/20% Coinsurance, \$10,000 Individual/\$20,000 Calendar-Year Coinsurance Maximum
- \$6,250 Individual/\$12,500 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 OR Parent Legal/Guardian (if policy for a minor)	(Please Print) X	OFFICE USE ONLY
	(Please Sign) X _____ Date	
New Policyholder	X _____ 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

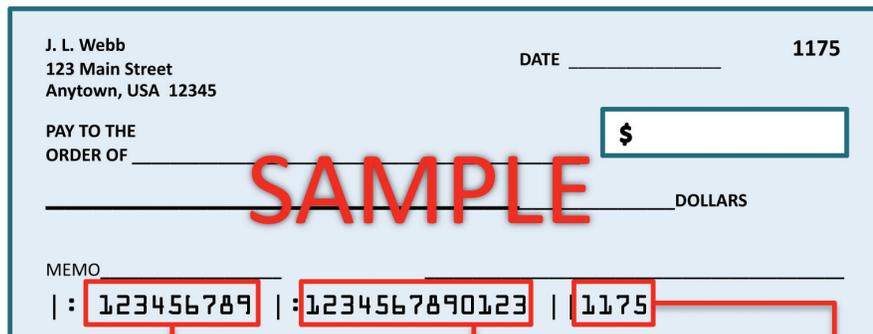
Currently, the insured's premium is drafted and the account information has changed

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

SERFF Tracking #:

ARBB-128657133

State Tracking #:**Company Tracking #:**UNDCHG FORM (R10/12), U-65 CF
NONUND (R1...**State:**

Arkansas

Filing Company:

Arkansas Blue Cross and Blue Shield

TOI/Sub-TOI:

H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name:

Revised Application

Project Name/Number:

Application/UndChg Form (R10/12), U-65 CF NonUnd (R10/12)

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	09/07/2012
Bypass Reason:	Not required.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	09/07/2012
Bypass Reason:	Already attached.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	09/07/2012
Bypass Reason:	Not required.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	09/07/2012
Bypass Reason:	Not PPACA related		
Comments:			