



This form is used only for Active Employees of Arkansas based employer groups that live outside the Health Advantage Service Area (State of Arkansas) for more than 90 days. If approved, the Employee and family members may access services covered by Health Advantage on the employee's group health plan. Services are covered at the In-Network benefit level when provided by **BlueCard** providers (Blue Cross and/or Blue Shield Traditional Network participating providers) and billed with the XCH prefix and the Member's ID number through the Local health plan. Claims are routed electronically to Health Advantage. If approved for payment, the Member's out-of-pocket expenses are limited to the Member's In-Network Deductible, Copayment and/or Coinsurance. The Member is responsible for the difference between the billed and allowed charges for services provided by non-participating BlueCard providers. Covered services received in the State of Arkansas are covered according to the employee's group health plan Evidence of Coverage. Renewal is not required for eligible Active Employees that permanently reside outside the Service Area. If you are an active employee of a new group or a new hire applying for health plan coverage on Health Advantage, please attach this form to your enrollment application.

APPLICATION FOR OUT OF AREA CLASSIFICATION

Subscriber ID # if current member (leave blank if new enrollee) _____

Subscriber Name _____ SSN _____

Address _____

Work phone _____

Home phone _____ Effective date _____ End date (if temporary) _____

Group name _____ Group number (if known) _____

Eligible dependents (spouse, child, or college age student):

Name _____ (spouse, child, student) resides with employee YES NO

Name _____ (spouse, child, student) resides with employee YES NO

Name _____ (spouse, child, student) resides with employee YES NO

For dependent student(s), please provide school information (required): Number of hours _____

Name and Location of College _____

Dependents not residing with employee: _____

Mailing Address _____

(A separate ID card will be mailed to member(s) not living with Subscriber)

Subscriber Signature _____ Date _____

Group Administrator Signature _____ Date _____

For Health Advantage Office Use Only: _____ Class Code Approved Not approved

New Application Renewal Effective date _____ Expiration date (if applicable) _____

Group Renewal Date _____ Signature _____ Date _____

(Signed copy of application mailed to Subscriber)

Mail to: Health Advantage Membership, P.O. Box 8069, Little Rock, AR 72203-8069 FAX: 501-301-6869