



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

ID #

Group Name:

Group #:



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

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

**CHANGE REQUEST FORM**

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

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

Terminate/Cancel Employee: Date of Termination: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Terminate coverage for a Family Member :

1. Member Name: \_\_\_\_\_ Termination Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

2. Member Name: \_\_\_\_\_ Termination Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

USAbLe Life Insurance – Beneficiary Change

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

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

First Name	MI	Last Name	Date of Birth	Relationship
			/   /	
			/   /	

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

Select or Change Primary Care Physician (PCP)

1. Member Name \_\_\_\_\_ PCP Name: \_\_\_\_\_ PCP # : \_\_\_\_\_

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

2. Member Name: \_\_\_\_\_ PCP Name: \_\_\_\_\_ PCP # : \_\_\_\_\_

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

In signing below, I represent that the statements and answers given in this application are true, complete and correctly recorded. I understand that any fraudulent statement, omission, or material misrepresentation may result in cancellation of any coverage issued in reliance thereon, and that Arkansas Blue Cross and Blue Shield, Health Advantage, and/or USAbLe Life may recover monies and damages incidental and consequential to that result.

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

Member Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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