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

Email: Groupaccounts@arkbluecross.com
Mail: Arkansas Blue Cross and Blue Shield
ATTN: Customer Accounts
PO Box 2181
Little Rock, AR 72203-9974
Fax: 501-378-3248

ID #

Group Name:

Group #:

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

Email: HAcustaccts@arkbluecross.com
Mail: Health Advantage
ATTN: Customer Accounts
PO Box 8069
Little Rock, AR 72203-8069
Fax: 501-301-6869

CHANGE REQUEST FORM

First Name	M.I.	Last Name	Social Security No.	Date of Birth / /

Home Address ❑ Check if Changed	Phone # ❑ Check if Changed

Change coverage as indicated below:

❑ Name Change Current Name: ______________ New Name: ______________

❑ 1095 Reporting Transfer to Tax ID (EIN) ______________

❑ Terminate/Cancel Employee Date of Termination: ____/____/____

Has the employee being terminated contributed to the premium past the termination date requested? ❑ Yes ❑ No

❑ Gender Change: The health plan currently shows my gender as: ❑ Male ❑ Female
Change the health plan records to show my gender as: ❑ Male ❑ Female

❑ Cancel health and retain LIFE Only coverage Date of Termination: ____/____/____

❑ Terminate coverage for a Family Member

1. Member Name: ______________ Termination Date: ____/____/____
2. Member Name: ______________ Termination Date: ____/____/____

Has the employee being terminated contributed to the premium past the termination date requested? ❑ Yes ❑ No

❑ 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	M.I.	Last Name	Date of Birth	Relationship
			/ /	
			/ /	

❑ 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