

ID #

Group Name:

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

**Email:** hacaenrollment@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			Phone #	
<input type="checkbox"/> Check if Changed			<input type="checkbox"/> 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