Change request form

Group name		
Medical group number	**Dental group number**	**Vision group number**
Medical member ID number	**Dental member ID number**	**Vision member ID number**

First name	Middle initial	Last name

Social Security number Check if SSN corrected	Date of birth (mm/dd/yy) Check if DOB corrected	Phone Check if phone changed

Street or PO box Check if address changed	City	State	ZIP

Change coverage as indicated below:

Name change: Current name: ______________________ New name: ______________________

1095 reporting: Transfer to Tax ID (EIN): ______________________

Move to division/package number: ______________________

Terminate/Cancel employee: Date of termination (mm/dd/yy): ______________________
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 (mm/dd/yy): ______________________

Terminate coverage for a family member

1. Member name: ______________________ Date of termination (mm/dd/yy): ______________________
2. Member name: ______________________ Date of termination (mm/dd/yy): ______________________

USAble Life Insurance – Beneficiary Change

First name	M.I.	Last name	Date of birth (mm/dd/yy)	Relationship	%

Select or Change Primary Care Physician (PCP)

1. Member name: ______________________ PCP name: ______________________ PCP number: ____________
   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 signed (mm/dd/yy)
Group administrator signature	**Date signed** (mm/dd/yy)

Small Group Account Management

Paper Application and Change Form Submissions

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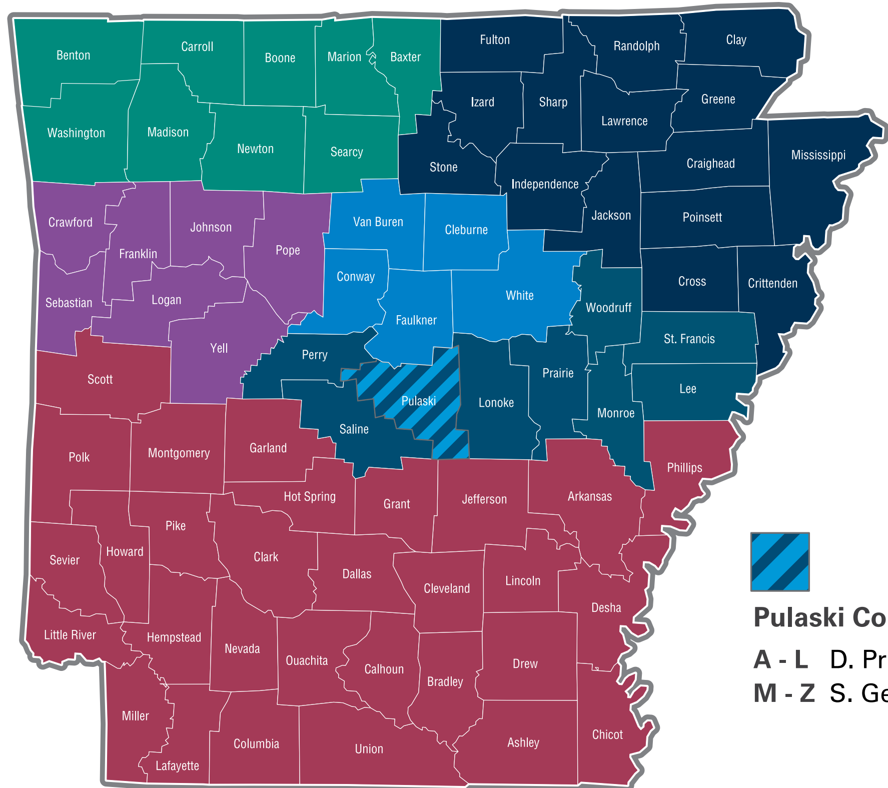

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