# Individual/Family dental | Change form

**MUST BE SUBMITTED ELECTRONICALLY. PDF FOR RECORDING DATA ONLY**

## Section 1 - Current policyholder information

| Member ID number | Group number | Date of birth |
|---|---|---|
| | | |

| First name | M.I. | Last name |
|---|---|---|
| | | |

| Primary phone number | Alternate phone number | Email | Preferred contact method |
|---|---|---|---|
| | | | ☐ Email ☐ Phone |

## Changes to be made

You may skip section(s) that do not apply to the change(s) you are making.
However, you must return all pages - even if blank

## Section 2 - Address change

| Residential street | City | State | ZIP | County |
|---|---|---|---|---|
| | | | | |

| Mailing street | City | State | ZIP |
|---|---|---|---|
| | | | |

| Billing street | City | State | ZIP |
|---|---|---|---|
| | | | |

## Section 3 - Name change

| | First name | Middle initial | Last name |
|---|---|---|---|
| From: | | | |
| To: | | | |

**Is this name change as a result of marriage?**
☐ Yes ☐ No Marriage date:

**Is this name change as a result of divorce?**
☐ Yes ☐ No Divorce date:

**Other reason for change**

Date of change:

## Section 4 - Billing change

☐ **Monthly bank draft** (Must complete attached bank draft form) ☐ **Monthly direct billing** (Paper bill)

## Section 5 - Delete person(s) from the policy

| First name | M.I. | Last name | Suffix | Date of birth (mm/dd/yyyy) | Reason code* (see below) | Date of change |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

***Reason codes:** 1 - Divorce 2 - Aging off 3 - Marriage 4 - Death 5 - Other

## Section 6 - Ownership change

| | First name | Middle initial | Last name |
|---|---|---|---|
| From: | | | |
| To: | | | |

## Section 7 - Split policy

Indicate the name of the covered person(s) you want covered on a separate policy with identical coverage.

| First name | M.I. | Last name | Suffix | Date of birth (mm/dd/yyyy) | Reason code* (see below) | Date of change (mm/dd/yyyy) |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**Reason codes:** 1 - Divorce 2 - Aging off 3 - Marriage 4 - Other (specify below)

Please provide address information for new policyholder ONLY:

| | | | |
|---|---|---|---|
| **Residential street** | **City** | **State** | **ZIP** |
| **Mailing street** | **City** | **State** | **ZIP** |
| **Billing street** | **City** | **State** | **ZIP** |

**Please set up the billing mode for my new policy**

☐ **Monthly bank draft** (Must complete attached bank draft form) ☐ **Monthly direct billing** (Paper bill)

## Section 8 - U.S. citizenship status

Additional information may be required.

☐ Yes ☐ No **Are all applicants U.S. citizens? If "No", please provide the name(s) of the applicant(s) who are not U.S. citizens.**

Name

Name

## Section 9 - Adding spouse or dependent(s)

Please add the following dependent(s):

**IMPORTANT NOTE:** Children age 26 and older must apply on their own

| First name | M.I. | Last name | Suffix | Relationship | Sex | Date of birth | Social Security no. |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |

Waiting periods do not apply to children age 18 and under.

The **6-month waiting period** for Minor Restorative services (Silver, Gold or Platinum) and the **6-month waiting period** for Major Restorative services (Gold or Platinum) will be waived if you meet the following criteria:

1. Your application is received within **30 days** of the termination date of your previous coverage; and
2. No later than **60 days** from the effective date of your new policy with Arkansas Blue Cross and Blue Shield, you provide us with a copy of your previous dental policy Certificate of Coverage which reflects the policy's effective and termination dates.

**You may include these documents with your change form. If you are submitting these documents after submission of your change form, fax them to Arkansas Blue Cross at 501-378-3752 or email them to CRMCustomerService@arkbluecross.com.**

## Section 9 - Adding spouse or dependent(s) *(Continued)*

☐ Yes ☐ No **Are all the added individual(s) permanent, legal residents of Arkansas? If "no," please provide:**

Name

Address

Reason

☐ Yes ☐ No **Have any of the proposed insureds had any other dental coverage within the last 12 months? If yes, list:**

| Name | Effective date | Termination date |
|---|---|---|
| | | |
| | | |
| | | |

## Please read before signing

I UNDERSTAND: (1) This application may be rejected. (2) If accepted, the insurance applied for shall not become effective until the date shown on my schedule of benefits and the adjusted premium, if applicable, is paid in full. (3) If my application is accepted relying on my representations on this document, any coverage which may be issued to me shall be invalid if based on false information. (4) My signature authorizes Arkansas Blue Cross and Blue Shield to coordinate benefits under this policy with other insurance I have which is subject to coordination. (5) Arkansas Blue Cross and Blue Shield may phone me for additional information that may help with the timely processing of my application. In signing below, I: represent that the statements and answers given in this application and any signed and dated addendum to this application are true, complete and correctly recorded.

☐ **I certify that I signed this application in the state of Arkansas.**

**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.**

## Signature section (please sign appropriate line only)

**Current policyholder OR parent/legal guardian** (if policy for a minor)

| Please print | Please sign | Date signed |
|---|---|---|
| | | |

**New policyholder**

| Please sign | Date signed |
|---|---|
| | |

## Custodial parent section

| **Custodial parent's name** (please print) | **Telephone No.** |
|---|---|
| | |

**Custodial parent's address**

| Street or P.O. box | City | State | County | ZIP |
|---|---|---|---|---|
| | | | | |

| **Custodial parent's signature** | **Date signed** |
|---|---|
| | |

## For home ofice use only (Do not write in this space)

## Return instructions

**Please return this signed form to:**

Arkansas Blue Cross and Blue Shield
Attn: Change Request
PO Box 2181
Little Rock, AR 72203-2181

Fax: 501-378-3752
Email: CRMCustomerService@arkbluecross.com

# Pre-authorized bank draft | Monthly program sign-up form

Our monthly bank draft service makes premium payments easy and convenient for you. Just a few steps now help assure your payments are made accurately and timely.

1. **Complete the information below.**
1. **Mail this completed authorization form to:**

   Arkansas Blue Cross and Blue Shield
   Attn: Cashiers (Drafts)
   P.O. Box 3590
   Little Rock, AR 72203

## Important: Please read before signing

I authorize Arkansas Blue Cross and Blue Shield, USAble Life, and the BANK indicated below, to debit my Arkansas Blue Cross and/or USAble Life premium from my checking or savings account indicated below. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such time and manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) days' written notice of the BANK's termination of this agreement.

I understand that by revoking the Pre-Authorized Bank Draft Program after I have agreed to it, I also will be terminating my Arkansas Blue Cross and/or USAble Life coverage, UNLESS Arkansas Blue Cross and/or USAble Life has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorized Bank Draft Program withdrawal date.

I understand that an insufficient check fee will be assessed for any payment returned to Arkansas Blue Cross as a result of insufficient funds.

## Insured's information

| First name | Last name | | | |
|---|---|---|---|---|
| **Street address** | **Apt. no.** | **City** | **State** | **ZIP** |
| | | | | |

**Arkansas Blue Cross and Blue Shield member ID**

## Bank account information

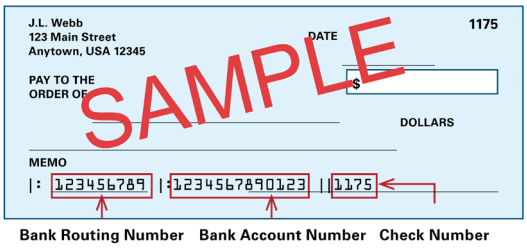
**Bank name**

**Name on account** (If different than the proposed insured)

| Routing number | Account number |
|---|---|
| | |

**Type of account**

☐ Checking ☐ Savings




## Signature

| Signature of bank account holder | Date |
|---|---|
| | |

After Arkansas Blue Cross receives and processes this completed authorization form, you will receive a letter providing the effective date of your first scheduled draft. We hope you find this bank draft service of value. It is our privilege to serve you. Thank you for your business!

**For office use only**
(please do not write in this space)

| ID No. |
|---|
| |
| **Effective date** |
| |

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