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

Dental Change Form

BlueCare® Dental
DentalBlue®
DentalBlue® Plus Vision

Return To: Arkansas Blue Cross and Blue Shield, Attn: Change Request, P.O. Box 2181, Little Rock, AR 72203-2181
or Fax to: 501-378-2236

1 CURRENT POLICYHOLDER INFORMATION

Member ID:_____ Group Number:_____ Date of Birth: ____/___/_____

First Name:_____ M.I.:_____ Last Name: _____

Primary Phone Number.: _____ Alternate Phone Number.: _____

CHANGES TO BE MADE

Please skip sections that do not apply to the change(s) you are making.

2 ADDRESS CHANGES

Residential Address: Street _____

City _____ State_____ Zip_____

Mailing Address: Street _____

City _____ State_____ Zip_____

Billing Address: Street _____

City _____ State_____ Zip_____

3 NAME CHANGE

From: First Name _____ M.I._____ Last Name _____

To: First Name _____ M.I._____ Last Name _____

Is this name change as a result of a marriage? ◯ Yes ◯ No Marriage Date: ____/____/_____

Is this name change as a result of a divorce? ◯ Yes ◯ No Divorce Date: ____/____/_____

Other reason for change:_____ Date of Change: ____/____/_____

4 BILLING CHANGE

☐ Monthly Bank Draft ☐ Quarterly Invoice ☐ Semi-Annual Invoice ☐ Annual Invoice
(Must complete attached bank draft form)

5 DELETE PERSON(S) FROM THE POLICY

First Name	M.I.	Last Name	Suffix	Date of Birth	**Reason Code* (see below)**	Date of Change

***Reason Codes:** 1 - Divorce 2 - Aging Off 3 - Marriage 4 - Death 5 - Other

6 OWNERSHIP CHANGE

Complete this section only when the primary policyholder is being removed. **Both the current policyholder and the new policyholder must sign the change form.**

From: First Name_____ M.I._____Last Name_____

To: First Name_____ M.I._____Last Name_____

7 SPLIT POLICY

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

First Name	M.I.	Last Name	Suffix	Date of Birth	**Reason Code* (see below)**	Date of Change

***Reason Codes:** 1-Divorce 2-Aging Off 3-Marriage 4-Other (specify above)

Please provide phone number, email and address information for new policyholder ONLY:

Primary Phone_____ Alternate Phone_____Email Name_____

Residential Address: Street _____

City _____ State_____ Zip _____

Mailing Address: Street _____

City _____ State_____ Zip _____

Billing Address: Street _____

City _____ State_____ Zip _____

Please set up the billing mode for my new policy:

☐ Monthly Bank Draft (Must complete attached bank draft form) ☐ Quarterly Invoice ☐ Semi-Annual Invoice ☐ Annual Invoice

8 CHANGE TYPE OF COVERAGE AND PLAN SELECTION

◯ Individual ◯ Individual and Spouse ◯ Individual and Child(ren) ◯ Individual/Spouse and Child(ren)

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.

◯ Yes ◯ No Do all dependents listed above live in 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," effective date: _____/_____/_____ Termination date: _____/_____/_____

Name of Company: _____ ID Number: _____

(Continued on page 3)

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's **(if policy for a minor)**	**X**	Date Signed
New Policyholder **(required if applying)**	**X**	Date Signed

For Home Office Use Only (Do not write in this space.)

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.**
2. **Mail this completed authorization form and the voided check 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 and the BANK indicated below, to debit my Arkansas Blue Cross 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 coverage, UNLESS Arkansas Blue Cross 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 _____

Address _____
Street Apt. No

_____
City State Zip

Arkansas Blue Cross and Blue Shield Member ID _____

Please check one of the following:

☐ Currently, the insured's premium is **not** drafted

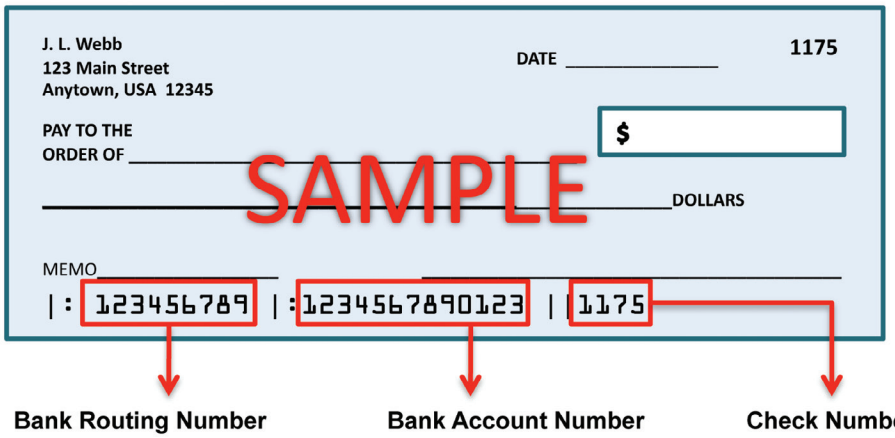
☐ Currently, the insured's premium is drafted and the account information has changed

BANK ACCOUNT INFORMATION

Bank Name: _____ Name on Account: _____
(If different than the insured)

Routing Number: _____ Account Number: _____

Type of Account: ☐ Checking ☐ Savings



SIGNATURE

Signature_____ Date_____
Signature of Bank Account Holder

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!

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For Office Use Only (Please do not write in this space)

ID NO.	EFFECTIVE DATE