



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

Arkansas Blue Cross and Blue Shield  
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Little Rock, AR 72203-9974  
Fax 501-378-3248  
E-Mail: [Groupaccounts@arkbluecross.com](mailto:Groupaccounts@arkbluecross.com)

ID #

Group Name:

Group #:



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

Health Advantage  
ATTN: Customer Accounts  
P O Box 8069  
Little Rock, AR 72203-8069  
Fax 501-301-6869  
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**CHANGE REQUEST FORM**

|            |      |           |                     |                      |
|------------|------|-----------|---------------------|----------------------|
| First Name | M.I. | Last Name | Social Security No. | Date of Birth<br>/ / |
|------------|------|-----------|---------------------|----------------------|

|  |   |
|--|---|
| Home Address <input type="checkbox"/> Check if Changed | Phone # <input type="checkbox"/> Check if Changed |
|--|---|

**Change coverage as indicated below:**

Name Change: Current Name : \_\_\_\_\_ New Name : \_\_\_\_\_

Cancel Employee:  Left Job  Other: Reason \_\_\_\_\_ Cancel Coverage \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Has the Employee being terminated contributed to the premium past the termination date requested?  Yes  No

Cancel coverage for a Family Member : \_\_\_\_\_ Last Month employee contributed premium: \_\_\_\_\_

|                       |                                      |  |
|-----------------------|--------------------------------------|--|
| 1. Member Name: _____ | Termination Date: ____ / ____ / ____ | Last Month employee contributed premium: _____ |
| 2. Member Name: _____ | Termination Date: ____ / ____ / ____ | Last Month employee contributed premium: _____ |

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

US Able Life Insurance – Beneficiary Change

US Able Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield and Health Advantage. US Able Life does not sell or service Arkansas Blue Cross and Blue Shield or Health Advantage products. US Able 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 | MI | Last Name | Date of Birth | Relationship |
|------------|----|-----------|---------------|--------------|
|            |    |           | / /           |              |

**The following changes apply to Health Advantage contracts only:**

Select or Change Primary Care Physician (PCP)  
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 performance of any act or practice constituting fraud or intentional misrepresentation of material fact may result in cancellation of any coverage issued in reliance thereon, and that Arkansas Blue Cross and Blue Shield, Health Advantage, and/or US Able 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.**

Employee Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Group Administrator Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_