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

Arkansas Blue Cross and Blue Shield
ATTN: Customer Accounts 2 North
P O Box 2181
Little Rock, AR 72203-9974
Fax 501-378-3248
E-Mail:Groupaccounts@arkbluecross.com

ID #

Group Name: Johnson Employer Support Services

Group #: 034112

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
E-Mail:HAcustaccts@arkbluecross.com

CHANGE REQUEST FORM

First Name	M.I.	Last Name	Social Security No.	Date of Birth / /

Home Address ☐ *Check if Changed*

Phone # ☐ *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

☐ 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	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 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.

_____ ___/___/___

Employee Signature Date

_____ ___/___/___

Group Administrator Signature Date

Form No. 10-77CRF R08/11