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, BlueAdvantage Administrators of Arkansas, 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)