Individual/Family health coverage | Change form

Read all instructions before completing this change form. The change form must be completed in its entirety and all pages must be submitted, even if they are blank, in order to be processed.

- This form is a legal document. If you are approved for coverage, it will become a part of your contract. Therefore, all information provided must be accurate and legible.
- This form must be completed in dark blue or black ink. Forms completed in **pencil** will not be accepted.
- If you make a mistake, mark through the incorrect information, initial it, date it, and provide the correct information.
- **What changes would you like to make?**
  - **Contact information:** Complete sections 1 and 2
  - **Address change:** Complete sections 1, 2, and 3
  - **Name change:** Complete sections 1, 2, and 5
  - **Delete person from policy:** Complete sections 1, 2, 4, and 6
  - **Add person to policy:** Complete sections 1, 2, 4, 7, 8, 9, 10 and 13
  - **Make someone else the primary policyholder:** Complete sections 1, 2, 4, 7, 8, 9, 10 and 11
  - **Split my policy into two or more policies:** Complete sections 1, 2, 4, 7, 8, 9, 10 and 12

Instructions

Changes to your evidence of coverage can only be made during the annual open enrollment period, unless the change is a result of a special election period or a qualifying life event, such as birth of a child, adoption, loss of other coverage, marriage, etc.

When you are completing this form, please refer to your Octave Blue Cross and Blue Shield identification card for your **Member ID** and Group Number. This information must be entered correctly under Section 1 in order to process your request.

Section 1 | Current subscriber information

Member ID	Group number	Date of birth

First name	Middle initial	Last name

Section 2 | Contact information

Primary phone number	Alternate phone number	Email address

How do you prefer we communicate with you during the application process? ☐ Phone ☐ Email

Note: By selecting your preferred contact method, you agree that all communication during the application process will be sent based on your selection; however, the alternate method(s) may be used if needed to reach you for purposes related to your application.

☐ **Important Opt-In Consent for Electronic Document Access and Delivery:** By providing your email address or by checking this box, you agree that after enrollment we may communicate with you and provide your policy information to you electronically for your convenience, such as your health insurance plan documents, benefits, ID cards, explanation of benefits, claim status, and legal notices regarding your financial, privacy and healthcare rights under federal law. Opting into electronic delivery also allows us to communicate with you electronically, either directly or through one of our contracted business associates, regarding your plan, identification of healthcare providers participating in our networks, disease management, health education and health promotion, preventive care options, wellness programs, treatment options, care coordination, and case management assistance for you in connection with your plan through [Arkansas Blue Cross Blue Shield, Health Advantage, Octave Blue Cross and Blue Shield or Skai Blue Cross and Blue Shield] ("Plan"). Please note that you are responsible for updating your contact information. This electronic delivery will continue through any policy renewals or other changes. Once you are an enrolled member of a plan, if you want to change your communication preferences, including to opt-out of electronic delivery, you may:

- Update your communication preferences and/or contact information at **blueprintportal.com**

OR

- Call the Customer Service number located on your member ID card

If you register for Blueprint portal access after enrollment, this allows you to access your documents and information electronically through your own password-protected account. With the Blueprint portal, your documents can be viewed or printed using your computer or mobile device. The website may be accessed with most versions of Chrome, Firefox, Microsoft Edge, or Safari. You may also set your preferences at **blueprintportal.com**.

Consent to electronic delivery is not a condition of purchase, enrollment, or coverage. At no cost to you, you also may request a paper copy of a document, regardless of whether it is or has been delivered electronically.

By providing your mobile phone number, you agree that automated, informational text messages may be sent to you by or on behalf of your Plan to update you about new plan products and programs. You can opt-out of receiving such text messages at any time by responding STOP in a response text message. Standard mobile phone and/or text message charges may apply from your wireless provider. Frequency will vary.

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 3 | Address changes

Any change to your current address information can be completed in this section. We have provided three separate listings for this information. Only complete for addresses that are changing.

Residential – This address will be noted as your physical place of residence.

Mailing – Correspondence such as letters and Explanation of Benefits (EOBs) will be mailed to this address.

Billing – All billing invoices will be mailed to this address.

A person must be lawfully present in the U.S. for the entire period of enrollment.

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

NOTE: If the only change you want to make is an address change, you are not required to submit a Change Form. You may simply call Customer Service at **800-800-4298**, and a representative can change your address quickly and easily.

Section 4 | Evidence of coverage change eligibility

Qualifying life event changes allow you to make changes to your evidence of coverage outside of the annual open enrollment period. **Please ensure all documentation is included.** Such events include, but are not limited to:

- Divorce/Legal Separation (requires a copy of divorce decree/legal separation)
- No longer an Arkansas resident (requires a date of move or date of notification)
- Marriage (requires a copy of the marriage certificate)
- Becoming eligible for other coverage (requires proof of eligibility of other coverage)
- Death (requires a copy of death certificate)

Check all applicable boxes below that support your eligibility to apply for this evidence of coverage and – if applicable – provide date of qualifying life event.

Date

☐ 1–Annual Open Enrollment Period: **[Nov 1 - Dec 15, Nov 1 - Jan 15]**

☐ 2–Birth

☐ 3–Adoption

☐ 4–Death

☐ 5–Marriage

☐ 6–Divorce or Legal Separation

☐ 7–New Guardianship/Legal Custody/ Court Order to Add Child

Date

☐ 8–Loss of Minimum Essential Coverage

☐ 9–Non-calendar Year Policy expires outside OEP (This is a one-time SEP, which will be used for those losing coverage due to the expiration of a non-grandfathered policy.)

☐ 10–New coverage becoming available as a result of a permanent move

Date

☐ 11–Errors, misinterpretation, in action by the Exchange, HHS, or their agents

☐ 12–QHP Contract Violation in relation to an individual

☐ 13–Loss of eligibility for APTC

☐ 14–Same sex marriage

☐ 15–Eligible for other coverage

NOTE: If application is **not** received during the Open Enrollment Period, we must receive appropriate documentation with this application to confirm qualifying life event/special election period (i.e. copy of marriage license, Certificate of Creditable Coverage from previous insurance company, legal guardianship/custody documentation, etc.) no greater than 60 days before triggering event and no later than 60 days after triggering event, except in the case of birth where the application must be received no later than 90 days after birth. Birth certificate required **only** if newborn (child 0-90 days old, as of received date) is applying for coverage.

Section 5 | Name change

Documentation is required for any name change request. Please complete and attach appropriate documentation such as a copy of your marriage license, divorce decree, adoption papers or other court papers to support the change.

From:	**First name**	**Middle initial**	**Last name**
To:	**First name**	**Middle initial**	**Last name**

Section 6 | Delete person(s) from the evidence of coverage

In the event you would like to **terminate coverage** for a member, including the subscriber, you can do so by completing this section.

OR

You have the option to **maintain the person's coverage** by splitting him/her off onto a new individual evidence of coverage with identical coverage. This will completely remove him/her from your coverage and create a new evidence of coverage for the member. You can make this change by completing **Section 12 – Split Evidence of Coverage.** A signature is required by both the current subscriber and new subscriber.

Important Note: Complete one change form for each new evidence of coverage you are requesting.

First name	M.I.	Last name	Suffix	Reason

Section 7 | Adding spouse or dependent(s)

Qualifying life event changes allow you to make changes to your evidence of coverage outside of the annual open enrollment period. Such events include, but are not limited to:

- Obtaining guardianship, legal custody of a child, or court order requiring coverage for a dependent (requires proof of guardianship, legal custody or court order)
- Loss of Eligibility (requires a Certificate of Creditable Coverage)
- Marriage (requires a copy of the marriage certificate)

First name	M.I.	Last name	Suffix	Relationship	Sex	Date of birth (mm/dd/yyyy)	Social Security number
				Self			

Section 8 | U.S. citizenship status

For any applicant who is not a U.S. citizen, a copy of his/her Permanent Resident VISA or Green Card issued by the U.S. Citizenship and Immigration Services may be requested. A person must be lawfully present in the U.S. for the entire period of enrollment.

☐ 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:

Name:

Section 9 | Household information

☐ Yes ☐ No **Are all applicants permanent, legal residents of Arkansas? If "no," please provide reason and his/her name and address:**

Name

Address

Reason

Name

Address

Reason

Section 10 | Current/Previous insurance coverage

☐ Yes ☐ No **a. Will the coverage applied for replace or change current hospital, medical or major medical insurance if this coverage is approved by Octave Blue Cross and accepted by the applicant?**

i. If "yes," please provide name and phone number of carrier:

ii. If "yes," does the **coverage** have a specified termination date? If so, please provide date:

iii. If "yes," and the coverage does not have a specified termination date, will the coverage terminate if approved by Octave Blue Cross and accepted by the applicant? ☐ Yes ☐ No

☐ Yes ☐ No **b. Have any applicants recently lost employer-sponsored health coverage?* If "yes," please provide:**

Name	Carrier name	Termination date
Name	Carrier name	Termination date

☐ Yes ☐ No **c. Have any applicants recently "involuntarily" lost other health coverage?* If "yes," please provide:**

Name	Carrier name	Termination date
Name	Carrier name	Termination date

☐ Yes ☐ No **d. Will any applicants be <u>continuing</u> any other health insurance? If "yes," please provide:**

Name	Carrier name	ID number
Name	Carrier name	ID number

☐ Yes ☐ No **e. Are any applicants covered by Medicaid (including AR Kids First)? If "yes," please provide name(s) below:**

Name:

Name:

☐ Yes ☐ No **f. Are any applicants covered by or eligible for Medicare Part A or Part B or Medicare Advantage (Part C)? If "yes," please provide name(s) below:**

Name:

Name:

*When your current policy ends, you may be given a Certificate of Creditable Coverage (COCC). A COCC is issued by your previous health insurance company and provides proof of prior coverage. Once you receive a COCC, please provide us a copy.

Section 11 | Ownership change

If both the subscriber and spouse are retaining coverage, but you would like to change the ownership of the evidence of coverage from the current subscriber to the spouse, complete this section. **Both the current subscriber and new subscriber must sign the change form.**

From:	**First name**	**Middle initial**	**Last name**
To:	**First name**	**Middle initial**	**Last name**

Section 12 | Split evidence of coverage

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 event**

Primary phone number	**Alternate phone number**	**Email address**

Please provide address information for new Subscriber ONLY:

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

Section 13 | Tobacco usage

☐ Yes ☐ No Does any new or existing member currently use any form of tobacco? If "yes," please provide the following:

Name(s):

Please read before signing

I UNDERSTAND: (1) The agent or broker involved in this health coverage transaction may receive compensation compensation from USAble HMO, Inc. d/b/a Octave Blue Cross and Blue Shield (hereafter referred to as Octave Blue Cross) or one of its affiliates, for services related to the placement of this health care coverage. Any such compensation is included in the premium paid by the subscriber. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker. (2) Any coverage which may be issued to me shall be invalid if based on intentional misrepresentation of material fact provided by me on the application. (3) Octave Blue Cross may phone me for additional information that may help with the timely processing of my application.

In signing below, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded; (b) understand that if intentionally fraudulent misstatements were made, Octave Blue Cross may take legal action at any time; (c) understand my signature authorizes the Octave Blue Cross to coordinate benefits under this evidence of coverage with other insurance I have which is subject to coordination; (d) agree that this application shall be valid without time limit; (e) agree that a photocopy of this application shall be as valid as the original, and I understand that a copy is available to me upon request. 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.

This evidence of coverage does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. The coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact Octave Blue Cross or your agent if you wish to purchase pediatric dental coverage or a stand-alone services product.

Rates are based on where you and any covered dependents live in Arkansas and tobacco use.

Arkansas Blue Cross and Blue Shield, its affiliates and partners may contact you, either directly or through a business associate, using your email address or telephone number regarding your health insurance plan or other promotional opportunities. You can manage your preferences or unsubscribe in Blueprint Portal at **blueprintportal.com**.

Octave Blue Cross does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

You may review our privacy and non-discrimination notices at **arkbluecross.com/privacy**, **arkbluecross.com/financial-privacy** and **arkbluecross.com/notice**.

Signature section (please sign appropriate line only)

Current subscriber OR parent/legal guardian (if not policy for a minor)

Please print	Date
Please sign	Date

Office use only

New subscriber

Please sign	Date

Custodial parent section

If any applicant under age 18 (primary applicant or dependent), named on this application, does NOT reside with the primary applicant or the parent/guardian indicated in Section 1, the custodial parent's signature is also required.

Custodial parent's name (please print)		**Phone number**	
Custodial parent's address (Street or PO box)	**City**	**State**	**ZIP**
Custodial parent's signature		**Date signed**	

This application is valid for 90 days only when completed and signed.

Return instructions

- Any **attachments** submitted with the change form must be signed and dated.
- **Do not send any money with this change form.**
- Please ensure all required parties have signed and dated the change form prior to submission.
- **We strongly recommend you make a copy of this completed change form for your records.**

NOTE: Additional documentation required should be faxed to Customer Service at **501-378-3752** or emailed to crmcustomerserviceao@arkansasoctave.com immediately following the submission of the application.

Return to:
Octave Blue Cross
Attn: CRM Operations and Service
P.O. Box 2181
Little Rock, AR 72203-2181

OR

Fax to: 501-378-3752
E-mail: crmcustomerserviceao@arkansasoctave.com

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

NOTICE OF LANGUAGE ASSISTANCE, AUXILIARY AIDS/SERVICES AND NON-DISCRIMINATION NOTICE

We provide free language assistance, appropriate auxiliary aids and services, and reasonable modifications to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in various formats (large print, audio, accessible electronic formats, other formats), and language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call or contact Customer Service at 1-800-238-8379 (TTY:771) or Civil Rights Coordinator.

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in assessable formats are available free of charge. Call 1-800-238-8379 (TTY: 711) or speak to your provider.

Spanish: ATENCIÓN: Disponemos de servicios gratuitos de asistencia lingüística. También hay disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-238-8379 (TTY: 711) o hable con su proveedor.

Chinese Simplified: 注意：提供免费语言服务。此外，免费提供适合残障人士使用的辅助和支持服务。请致电 1-800-238-8379 (TTY: 711)或联系您的服务提供商。

Chinese Traditional: 注意：我們提供免費的語言協助服務，以及免費的適當輔助工具和其他服務，讓您能夠獲得無障礙格式的資訊。請撥打 1-800-238-8379 (TTY: 711)或諮詢您的服務提供者。

Tagalog: PAUNAWA: Available para sa iyo ang mga libreng serbisyo sa tulong sa wika. Available rin nang walang bayad ang mga naaangkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-238-8379 (TTY: 711) o makipag-usap sa iyong provider.

French: ATTENTION : Des services d'assistance linguistique sont gratuitement mis à votre disposition. Des aides et services auxiliaires appropriés visant à vous informer dans des formats accessibles sont également mis à votre disposition gratuitement. Appelez le 1 800 238 8379 (TTY : 711) ou discutez avec votre prestataire.

Vietnamese: CHÚ Ý: Các dịch vụ hỗ trợ ngôn ngữ sẽ được cung cấp miễn phí cho quý vị. Các dịch vụ và hỗ trợ giao tiếp phù hợp nhằm cung cấp thông tin ở các định dạng dễ tiếp cận cũng được cung cấp hoàn toàn miễn phí. Hãy gọi 1-800-238-8379 (TTY: 711) hoặc trao đổi với nhà cung cấp của quý vị.

German: HINWEIS: Ihnen stehen kostenlose Sprachmittlungsdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zum barrierefreien Zugang zu Informationen stehen ebenfalls kostenfrei zur Verfügung. Rufen Sie 1-800-238-8379 (TTY: 711) an oder sprechen Sie mit Ihrem Leistungserbringer.

Korean: 주의: 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 제공됩니다. 1-800-238-8379 (TTY: 711)번으로 전화하거나 담당 서비스 제공자에게 문의하십시오.

Russian: ВНИМАНИЕ! Вам доступны бесплатные услуги языковой поддержки. Приемлемые вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-238-8379 (TTY: 711) или обратитесь к своему поставщику услуг.

Arabic: ملاحظة: خدمات المساعدة اللغوية متاحة لك مجاناً، كما أن وسائل وخدمات المساعدة الإضافية المناسبة لتوفير المعلومات بصيغ يسهل عليك الوصول إليها متاحة مجاناً أيضاً. يرجى الاتصال على الرقم: 1-800-238-8379 (TTY: 711) أو التحدث إلى مقدم الرعاية

Hindi: ध्यान दें: आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। आसान फ़ॉर्मैट में सूचना उपलब्ध कराने के लिए उचित सहायक साधन और सेवाएं भी निःशुल्क उपलब्ध हैं। 1-800-238-8379 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Italian: ATTENZIONE: Ha a disposizione servizi di assistenza linguistica gratuiti. Potrà usufruire gratuitamente anche di sussidi e servizi ausiliari appropriati per ottenere le informazioni in formati accessibili. Chiami il numero 1-800-238-8379 (TTY: 711) o chieda al suo operatore sanitario.

Portuguese: ATENÇÃO: Serviços gratuitos de assistência linguística estão disponíveis para você. Ajudas e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-238-8379 (TTY: 711) ou fale com seu provedor.

French Creole: ATANSYON: Genyen sèvis asistans lang gratis disponib pou ou. Epitou, genyen lòt èd ak sèvis apwopriye disponib gratis pou ede moun jwenn enfòmasyon nan yon fòma ki aksesib. Rele 1-800-238-8379 (TTY: 711) oswa pale ak founisè w la.

Polish: UWAGA: może Pan/Pani skorzystać z bezpłatnych usług pomocy językowej. Odpowiednie dodatkowe pomoce i usługi w zakresie zapewniania dostępu do informacji w przystępnym formacie również są dostępne bezpłatnie. Prosimy dzwonić pod numer 1-800-238-8379 (TTY: 711) lub porozmawiać z lekarzem.

Japanese: 注意：無料の言語サポートサービスをご利用いただけます。アクセシブルなフォーマットで情報を提供するための適切な援助やサービスも無料でご利用いただけます。1-800-238-8379（TTY：711）にお電話いただくか、医療提供者にご相談ください

NON-DISCRIMINATION NOTICE

Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex.

If you believe that we have failed to provide these language assistance or auxiliary aids and services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex.

Civil Rights Coordinator
601 Gaines Street, Little Rock, AR 72201
Phone: 1-844-662-2276 (TTY: 711)
You can file a grievance in person, by mail, or by email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201
Phone: 1-800-368-1019; TDD: 1-800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.