



Change Request Form

Return to: CHIP Program
P. O. Box 1460
Little Rock, AR 72203
(800) 285-6477

Important: Complete any applicable sections in ink, and sign and date at bottom of page.

** indicates required information*

* ID Number: _____

* Full Name: _____
Last First M.I.

NAME CHANGE:

Important: If changing name, please indicate new name above.

Change my name from: _____ to: _____

ADDRESS CHANGE:

New Address:

Address: _____
Mailing Address or P.O. Box

City State ZIP Code

Home Phone: () _____ Alternate Phone: () _____

TOBACCO USE CHANGE:

Change my Tobacco Use status to:

- Tobacco User
- Non-Tobacco User (must attach a letter from your Physician stating that you have not used tobacco in the last 12 months)

BILLING METHOD CHANGE:

Change my billing method to:

- Quarterly
- Monthly Bank Draft (must attach a completed Pre-Authorized Bank Draft Form and voided check)

DEDUCTIBLE CHANGE:

Choose one option below to change your deductible:

- Increase Annual Deductible to \$1,250 (HSA-Qualified Plan).
- Increase Annual Deductible to \$5,000.
- Increase Annual Deductible to \$10,000.

- Decrease Annual Deductible to \$1,000.
- Decrease Annual Deductible to \$1,250 (HSA-Qualified Plan).
- Decrease Annual Deductible to \$5,000.

Deductible increases received before the 15th of the month will become effective the 1st of the next month.

Deductible decreases can only be made effective January 1st of any year. Submit requests by December 15th to decrease your deductible.

CANCEL COVERAGE:

Check box and fill in date of desired cancellation: (Note: CHIP can only cancel policies on the last day of the month.)

Cancel my CHIP Policy effective: _____

Reason for cancellation: Medicare - Effective _____ Other Reason _____
 Other Insurance - Effective _____

SIGNATURE AND DATE:

* Signature of Policyholder **X** _____ Date Signed _____

Parent/Guardian Signature _____ Date Signed _____
*If policy for a minor or incompetent **X**