BlueAdvantage Administrators of Arkansas
An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 1460
Little Rock, AR 72203-1460

CHANGE FORM

Section 1: Employment and Coverage Information

Name of Employer	Name of Employee		Social Security #	Division #
	Last Name	First Name	- -	

Section 2: Employee Information

Type of Change	Current	Change	Effective Date
☐ Name change			
☐ Address change			
☐ Change in type of coverage and/or division # change	❑ Single Medical ❑ Family Medical ❑ Single Dental ❑ Family Dental ❑ Single COBRA ❑ Family COBRA ❑ Other_____ Division # _____	❑ Single Medical ❑ Family Medical ❑ Single Dental ❑ Family Dental ❑ Single COBRA ❑ Family COBRA ❑ Other_____ Division # _____	
❑ Termination of contract – Termination Date _____			

Section 3: Dependent Information

Add*	Drop	Date of Add/Drop	Last Name	First Name	MI	Birth Date Mo/Day/Yr	Sex M/F	Dependent Social Security #	Relationship to Employee	Full-time Student ✓	Handi-Capped ✓	Selected PCN Physician (if applicable)	Employer Use Only: Pre-ex condition excluding exp. date
☐	❑							- -					
☐	❑							- -					
☐	❑							- -					
☐	❑							- -					
☐	❑							- -					

*If you are adding a dependent who has other insurance, complete the following:

Policyholder's Name _____ Policyholder's Relation to Dependent _____ Policyholder's Date of Birth _____

Section 4: PCN Physician Transfer (for PCN groups only)

Name of employee or dependent(s) changing PCP _____ Current Physician _____ New Physician _____ Effective date _____

Section 5: Other — List any other requested changes in enrollment information.

Section 6: Signature (Please read before signing in ink)

In signing below, I represent that the statements and answers given on this form are true, complete and correctly recorded to the best of my knowledge and belief.

Signature of Applicant _____ Date _____ Employer/Group Representative Verification _____ Date _____