



Arkansas  
**BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

# VISION

## APPLICATION AND CHANGE FORM

Group No.:	Employer:	DEPT.:	DATE OF FULL-TIME EMPLOYMENT:	ID No.:
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### GROUP EMPLOYEE APPLICATION

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	SEX	SOCIAL SECURITY NO.
APPLICANT			MO. DAY YEAR		

### SECTION 1 | POLICY ELIGIBILITY

Check all applicable boxes below that support your eligibility, provide date of qualifying life event and documentation.

<input type="checkbox"/> 1-Annual Open Enrollment Period	Date	<input type="checkbox"/> 6-Marriage	Date
<input type="checkbox"/> 2-New Hire		<input type="checkbox"/> 7-New Adoption	
<input type="checkbox"/> 3-Waiving Coverage		<input type="checkbox"/> 8-New Guardianship/Legal Custody/Court Order to Add Child	
<input type="checkbox"/> 4-Loss of Minimum Essential Coverage		<input type="checkbox"/> 9-Other Reason: Ex. Rehire, ACA (give specific reason)	
<input type="checkbox"/> 5-Newborn			

**NOTE:** If application is not received during 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.).

### SECTION 2 | WHO IS APPLYING

Coverage Desired: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee, Spouse & Child(ren)

Please indicate under the relationship column below whether dependent children are natural, step or adopted.

First Name	M.I.	Last Name	Relationship	Sex	Date of Birth	Social Security No.
			Self			

### SECTION 3 | MARITAL STATUS

☐ Single (including widowed or divorced) ☐ Married (including separated)

### SECTION 4 | CONTACT INFORMATION

Street or P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Primary Phone Number ( ) \_\_\_\_\_ Work Phone Number ( ) \_\_\_\_\_ Email \_\_\_\_\_

### SECTION 5 | EMPLOYMENT STATUS

Job Title \_\_\_\_\_

☐ Hourly Hours Worked Weekly \_\_\_\_\_

☐ Salaried ☐ Other \_\_\_\_\_

Are you a current, active employee? ☐ Yes ☐ No

#### FOR OFFICE USE ONLY

C/T	PKG	DATE
EFF DATE	UND	
OTH		

**SECTION 6 | CURRENT/PREVIOUS VISION INSURANCE INFORMATION**  
(This section must be completed to process your enrollment application.)

For previous or continuing coverage please complete the following:  
(If covered by more than one insurance plan, use additional paper)

Insurance Company	Address	Phone
Policyholder Name	Date of Birth	Member ID#

List the following information for all family members covered by this policy (indicate those not residing in your household with a check ☒ mark)

First Name	Last Name	Relationship	<input checked="" type="checkbox"/>	Eff. Date of Coverage	End Date of Coverage

**SECTION 7 | CHANGE REQUEST SECTION**

Changes may be sent by: **Email:** Groupaccounts@arkbluecross.com  
**Fax:** 501-378-3248

**MAIL:** Arkansas Blue Cross and Blue Shield  
ATTN: Customer Accounts 2 North  
P.O. Box 2181  
Little Rock, AR, 72203-9974

**Change to individual due to:**

- ☐ Death – Date: \_\_\_\_\_
- ☐ Divorce – Date: \_\_\_\_\_
- ☐ Other: \_\_\_\_\_

**Change coverage as indicated below:**

- ☐ Name Change: \_\_\_\_\_
- ☐ Other – Explain: \_\_\_\_\_
- Current Name: \_\_\_\_\_
- New Name: \_\_\_\_\_

**CHANGE IN DEPENDENT STATUS**

Delete	Last Name	First Name	M.I.	Birthdate	Relationship	Sex	SSN	Date of Change	Reason (for deletion only)

**SECTION 8 | AUTHORIZATION & SIGNATURES**

I understand that no benefits for services of any kind are provided for treatment that was received prior to the effective date of my vision coverage.  
I do hereby authorize any optometrist, ophthalmologist, hospital or other provider of medical services or supplies to make available to Arkansas Blue Cross and Blue Shield upon request any and all medical records and facts pertaining to us and our physical condition.

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefits 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.**

Print Name of Applicant (Employee)

Signature of Applicant (Employee)

Date

Print Name of Employer/Group Representative\*

Signature of Employer/Group Representative\*

Date

\*Required for new hires and additions only.



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