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

Application for Vision Insurance Classic and Plus

Return To: Arkansas Blue Cross and Blue Shield, Attn: New Application, P.O. Box 2181, Little Rock, AR 72203-2181
or Fax to: 501-378-3752 or email to: CRMCustomerService@arkbluecross.com

1 WHO IS APPLYING

In the "Relationship" column below, please indicate **spouse, son, daughter, stepson, stepdaughter or dependent child** beside each dependent's name. (**Important Note**: Children ages 26 and older must apply on their own.)

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

2 PARENT/GUARDIAN (If policy is only for a child under age 18)

First Name	M.I.	Last Name	Relationship **(Check One)**
			☐ Mother ☐ Stepmother ☐ Guardian ☐ Father ☐ Stepfather

3 MARITAL STATUS

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

4 RESIDENTIAL ADDRESS (Must be permanent address - No P.O. Box, please)

Street | City | State AR | Zip

5 MAILING ADDRESS (Complete only if different from residential address)

Street or P.O. Box | City | State | Zip

6 BILLING ADDRESS (Complete only if different from residential address)

Street or P.O. Box | City | State | Zip

7 CONTACT INFORMATION

Primary Phone Number	Alternate Phone Number	Email Address	How do you prefer we communicate with you?
( )	( )		☐ Email ☐ Phone

8 HOUSEHOLD INFORMATION

☐ Yes ☐ No Are all applicants permanent, legal residents of Arkansas?

If "no," please provide: Name: _____ Address: _____

Reason: _____

FOR HOME OFFICE USE ONLY (Do Not Write In This Space)

I.D. No.	Group No.	Effective Date

(Continued on page 2)

9 BILLING MODE

☐ Monthly Bank Draft
(Must complete attached bank draft form)

☐ Monthly Direct Billing
(Paper bill)

10 U.S. CITIZENSHIP STATUS

Additional information may be required.

Are all applicants U.S. citizens? ☐ Yes ☐ No

If "No", please provide the name(s) of the applicant(s) who are not U.S. citizens.

Name:_____ Name:_____

Type of Permanent Visa or Permanent Green Card
USCIS Category: _____
Registration No.: _____

Issue Date Mo. Day Yr. / /

Expiration Date Mo. Day Yr. / /

11 PLAN SELECTION

☐ **Classic** ☐ **Plus**

PLEASE READ BEFORE SIGNING

I UNDERSTAND: (1) This application may be declined. (2) If accepted, the insurance applied for shall not become effective until the date shown on my identification card and the initial premium is paid in full. (3) If my application is accepted relying on my representations in this document, any coverage which may be issued to me shall be invalid if based on false information. (4) Arkansas Blue Cross and Blue Shield 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) agree that a photocopy of this authorization 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.

SIGNATURE SECTION (Please sign appropriate line only)

Proposed Insured **OR** Parent/Legal Guardian's **(if policy for a minor)**	**X**	Date Signed

This section to be completed by sales representative

Sales Rep License No. **(required)**	Sales Representative's Name (please print) **X**	Telephone No.
Agency Federal Tax ID No. **(if applicable)**	Sales Representative's Signature **X**	Date Signed

For Home Office Use Only (Do not write in this space.)

Home Office Endorsements

THIS APPLICATION IS VALID FOR 90 DAYS ONLY WHEN COMPLETED AND SIGNED.

Pre-Authorized Bank Draft

Monthly Program Sign-up Form

Our monthly bank draft service makes premium payments easy and convenient for you. Completing this simple form helps ensure your payments are made accurately and timely.

Important: Please Read Before Signing

I authorize Arkansas Blue Cross and Blue Shield and the BANK indicated below, to debit my Arkansas Blue Cross premium from my checking or savings account indicated below. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such time and manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) days' written notice of the BANK's termination of this agreement.

I understand that by revoking the Pre-Authorized Bank Draft Program after I have agreed to it, I also will be terminating my Arkansas Blue Cross coverage, UNLESS Arkansas Blue Cross has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorized Bank Draft Program withdrawal date.

I understand that an insufficient check fee will be assessed for any payment returned to Arkansas Blue Cross as a result of insufficient funds.

Proposed Insured(s) Information

First Name:_____ Last Name: _____

Address: _____

Street Apt. No.

_____

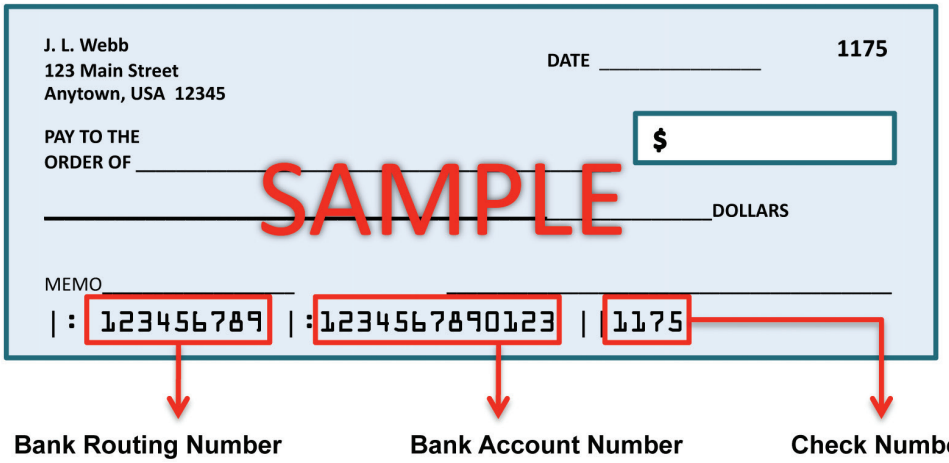
City State Zip

Bank Account Information

Bank Name:_____ Name on Account: _____
(If different than the proposed insured)

Routing Number:_____ Account Number: _____

Type of Account: ☐ Checking ☐ Savings



Signature

Signature_____ Date_____

Signature of Bank Account Holder

After Arkansas Blue Cross receives and processes this completed authorization form, you will receive a letter providing the effective date of your first scheduled draft. We hope you find this bank draft service of value. It is our privilege to serve you. Thank you for your business!

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ID NO.	EFFECTIVE DATE

Arkansas
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Policy Effective Date

All Arkansas Blue Cross Vision policies will be issued with a 1st of the month effective date based on the approval date (1st-15th **OR** 16th-31st) of your application. For example, if your application is approved on January 10, coverage will be effective February 1. If your application is approved on January 20, coverage will be effective March 1.

✓ Application Checklist

Have you . . .

- ❑ Answered all the questions?
- ❑ Signed and dated the application?
- ❑ Enclosed a completed Pre-authorized Monthly Bank Draft form signed by account holder (if monthly bank draft is requested)?
- ❑ Attached a voided check from account to be charged (if monthly bank draft is requested)?

Please return this application and bank draft form (if completed) in the business-reply envelope provided. If you did not receive an envelope, please mail to:

Arkansas Blue Cross and Blue Shield
P.O. Box 2181
Little Rock, AR 72203-2181

NON-DISCRIMINATION AND LANGUAGE ASSISTANCE NOTICE

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.

We provide free aids and services 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, contact our Civil Rights Coordinator.**

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
601 Gaines Street, Little Rock, AR 72201
Phone: 1-844-662-2276; TDD: 1-844-662-2275

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.

ATTENTION: Language assistance services, free of charge, are available to you. Call 1- 844-662-2276.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-662-2276 .

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-662-2276.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-662-2276

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-662-2276 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-662-2276.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-662-2276.

ملاحظة: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية مجانا. دعوة 1-844-662-2276 العدد.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-662-2276.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-662-2276.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-662-2276.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-662-2276.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-662-2276.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-662-2276 まで、お電話にてご連絡ください。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-662-2276.

ملاحظة. إذا كنت تتحدث باللغة الفارسية، والخدمات اللغوية المقدمة مجانا بالنسبة لك. يرجى الاتصال 1-844-662-2276

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-662-2276.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-662-2276 पर कॉल करें।

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-662-2276.

انتباہ: آپ اردو بولتے ہیں تو، زبان کی مدد کی خدمات بلا معاوضہ دستیاب ہیں. کال کریں 1-844-662-2276

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-662-2276.

LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-844-662-2276