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

P.O. Box 1460
Little Rock, AR 72203

Employee Name: _____ ID#: _____ Group#: _____

Do you or any members of your family have health insurance through a company other than BlueAdvantage Administrators?
You: Yes _____ No _____ **Your Spouse:** Yes_____ No_____ **Your Dependents:** Yes_____ No_____

If you responded **YES**, please complete the remaining portion of this form.

About You:
Name of Insurance Company: _____ Group/Policy Number:_____
_____ _____ _____ _____
Street Address of Insurance Company City State Zip Code
Policy Holder: _____ID Number: _____ Date of Birth: _____
Effective Date: _____ Termination Date (if applicable) _____ Coverage Includes: Medical _____ Dental _____ Vision ____
Coverage Type: Group Health Plan _____ Individual Health Plan _____ Retirement Plan _____ {retirement date: _____} COBRA Plan _____

About Your Spouse:
Name of Insurance Company: _____ Group/Policy Number:_____
_____ _____ _____ _____
Street Address of Insurance Company City State Zip Code
Policy Holder: _____ID Number: _____ Date of Birth: _____
Effective Date: _____ Termination Date (if applicable) _____ Coverage Includes: Medical _____ Dental _____ Vision ____
Coverage Type: Group Health Plan _____ Individual Health Plan _____ Retirement Plan _____ {retirement date: _____} COBRA Plan _____

About Your Dependents:
Name of Insurance Company: _____ Group/Policy Number:_____
_____ _____ _____ _____
Street Address of Insurance Company City State Zip Code
Policy Holder: _____ID Number: _____Date of Birth: _____
Effective Date: _____ Termination Date (if applicable) _____ Coverage Includes: Medical _____ Dental _____ Vision ____
Coverage Type: Group Health Plan _____ Individual Health Plan _____ Retirement Plan _____ {retirement date: _____} COBRA Plan _____

List dependents covered by other coverage:

Name	Date of Birth	Name	Date of Birth
_____		_____	
_____		_____	

Has coverage for your dependent children been affected by a Divorce Decree or by custody? Yes___ No____
(If yes, please send us a copy of the first page from the Divorce Decree and all pages that apply to health coverage.)

Are you, your spouse, or dependents covered by Medicare? Yes___ No ___ If Yes, please send us a photo copy of your Medicare ID Card.
Reason for Medicare: Over 65_____ Disability_____ Kidney Disease_____

Sincerely, BlueAdvantage Administrators
Customer Service Division
(800) 452-6199

Signature/Date: _____

***BlueAdvantage Administrators ofrece un servicio de interpretación para que usted pueda hacer preguntas en español o en otros varios idiomas. Si el representante que habla su idioma no está disponible, un intérprete puede ser conectado a la linea para poder ayudarlo con su pregunta.*

Ltr: S COB/<<OPn>>

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