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>>