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

Complete & Complete Plus Change Form

READ ALL INSTRUCTIONS BEFORE COMPLETING THIS CHANGE FORM. THE CHANGE FORM MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.

- This form is a legal document. If you are approved for coverage, it will become a part of your contract. Therefore, all information provided must be accurate and legible.
- This form must be completed in dark blue or black ink. Forms completed in **pencil** will not be accepted.
- If you make a mistake, mark through the incorrect information, initial it, date it, and provide the correct information.
- Do not use liquid paper, correction tape, or "white out" to correct any mistakes on this form.
- **What changes would you like to make?**
  - **Contact information** ➡ All policies: Complete sections 1, 2 and 3
  - **Address change** ➡ All policies: Complete sections 1, 2, 3 and 4
  - **Name change** ➡ All policies: Complete sections 1, 2, 3 and 5
  - **Add a spouse or dependent to a policy** ➡ Renewable Term policies only: Complete sections 1, 2, 3 and 6
  - **Delete person from policy** ➡ All policies: Complete sections 1, 2, 3 and 7
  - **Make someone else the primary policyholder** ➡ All policies: Complete sections 1, 2, 3 and 8
  - **Split my policy into two or more policies** ➡ All policies: Complete sections 1, 2, 3 and 9
  - **Delete/Change benefits** ➡ All policies: Complete sections 1, 2, 3, and 10
  - **Remove Surcharge** ➡ Renewable Term policies only: Complete sections 1, 2, 3, 6 and 11; subject to underwriting review

INSTRUCTIONS

When you are completing this form, please refer to your Arkansas Blue Cross and Blue Shield identification card for your **Member ID** and Group Number. This information must be entered correctly under Section 1 in order to process your request.

Effective Date: Approved changes become effective on the 1st of the month. The effective date for any changes will be the next available effective date following approval, unless otherwise requested.

Section 6

- For any applicant who is not a U.S. citizen, a copy of his/her Permanent Resident VISA or Green Card issued by the U.S. Citizenship and Immigration Services must be submitted with the application.
- Applicants must reside in the U.S. at least one year and must have a primary care physician in the U.S. prior to being eligible to apply for coverage.

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IMPORTANT NOTE: We cannot process your Complete/Complete Plus Change Form without this completed form.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, pharmacy benefit manager, or other provider of healthcare services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliate or agents information concerning services, supplies, benefit or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any healthcare item or service in relation to the healthcare provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices.

I understand that information re-disclosed may no longer be protected by federal privacy regulations. This authorization does not provide for the disclosure of psychotherapy notes as define in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, PO Box 2181, Little Rock, AR 72203-2181. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 et seq., the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 et seq. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 et seq. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

This authorization includes authorization to release information on the diagnosis and treatment of mental illness, alcohol, and drug use, as well as authorization to release information on the diagnosis, treatment, and testing results related to HIV-AIDS, and sexually transmitted diseases, unless otherwise restricted by applicable law.

Please note the following consequences if you decline to sign this authorization for release of your medical information, or if you later revoke it: in that event, we may be unable to process your application or evaluate a claim for coverage and would then deny your application or your claim for policy benefits.

This authorization must be signed by each applicant age 18 or older.

Applicants age 18 and older

Print Name(s)	Signature	Date

Applicants under age 18

List applicants under age 18 (Print Name).

	Parent/Legal Guardian's Signature (if policy for a minor)	Date

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COMPLETE & COMPLETE PLUS CHANGE FORM
For Current Policy

Return To: Arkansas Blue Cross and Blue Shield
Attn: CRM Operations and Service
P.O. Box 2181
Little Rock, AR 72203-2181

OR

Fax to: 501-378-3752
E-mail: CRMCustomerService@arkbluecross.com

SECTION 1 | CURRENT POLICYHOLDER INFORMATION

Member ID	Group Number	Date of Birth:

First Name	M.I.	Last Name

SECTION 2 | CONTACT INFORMATION

Primary Phone Number	Alternate Phone Number	E-mail Address

How do you prefer we communicate with you during the application process? ☐ E-mail ☐ Phone

Arkansas Blue Cross and Blue Shield may contact you, either directly or through a business associate, using your postal or email addresses, telephone numbers or other personal information, regarding your health insurance plan, healthcare providers participating in our networks, disease management, health education and health promotion, preventive care options, wellness programs, treatment or care coordination or case management activities of Arkansas Blue Cross.

SECTION 3 | REQUESTED EFFECTIVE DATE

What would you like your effective date to be? (**Note**: Changes can only become effective on the 1st of the month, unless change is due to birth or adoption.

Month	Day	Year
	01	

☐ Birth/Adoption

Month	Day	Year

CHANGES TO BE MADE

You may skip section(s) that do not apply to the change(s) you are making. However, you must return all pages — even if blank.

SECTION 4 | ADDRESS CHANGES

Any change to your current address information can be completed in this section. We have provided three separate listings for this information. Only complete for addresses that are changing.

Residential – This address will be noted as your physical place of residence.
Mailing – Correspondence such as letters and Personal Health Statement (PHS) will be mailed to this address.
Billing – All billing invoices will be mailed to this address.

Residential

Street	City	State	County	Zip

Mailing

Street	City	State	County	Zip

Billing

Street	City	State	County	Zip

SECTION 5 | NAME CHANGE

Documentation is required for any name change request. Please complete this section and attach appropriate documentation, such as a copy of your marriage license, divorce decree, adoption papers or other court papers to support the change.

From:	First Name	M.I.	Last Name

To:	First Name	M.I.	Last Name

SECTION 6 | ADD PERSON(S) TO POLICY

Please complete all sections below with information about the individual(s) you would like to add to your policy. Individual(s) cannot be added to Single Term policies. Individual(s) requested to be added to the policy are subject to underwriting. When adding a spouse, the individual must be age 17 or older. Newborns can only be added to the policy if the change form is received within 90 days from the date of birth. All other dependent additions – including adoptions, must be at least 6 months or older.

First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Security No.	Height	Weight
								ft. in.	lbs.
								ft. in.	lbs.
								ft. in.	lbs.

OTHER INSURANCE

☐ Yes ☐ No a. Are any added individual(s) covered by Medicaid (including AR Kids First)? If "yes," please provide name(s) below:

Added individual(s) Name:

Added individual(s) Name:

☐ Yes ☐ No b. Are any added individual(s) covered by Medicare? If "yes," please provide name(s) below:

Added individual(s) Name:

Added individual(s) Name:

☐ Yes ☐ No c. Are any added individual(s) Medicare disabled? If "yes," please provide name(s) below:

Added individual(s) Name:

Added individual(s) Name:

☐ Yes ☐ No d. Do you or any applicant have current Arkansas Blue Cross Blue Shield coverage? If "Yes," please provide:

ABCBS ID#

☐ Yes ☐ No e. Have you or any applicant had ABCBS coverage that has terminated within the last 6 months? If "Yes," please provide:

ABCBS ID#

ELIGIBILITY

☐ Yes ☐ No f. Is any male applying for coverage an expectant father or a potential adoptive father? If "Yes", please provide:

Added individual(s) Name:

☐ Yes ☐ No g. Is any female applying for coverage pregnant or a potential adoptive mother? If "Yes", please provide:

Added individual(s) Name:

☐ Yes ☐ No h. Has any added individual(s) ever consumed alcohol to excess, received treatment, or joined an organization for alcoholism or drug addictions? If "yes," please provide name(s) below:

Applicant's Name	Complete Name and Address of Treatment Facility or Physician	Date Last Treated	Reason for Treatment

☐ Yes ☐ No i. Has any added individual(s) ever used any addictive drug or substance for purposes other than recommended by your physician? If "yes," please provide name(s) below:

Applicant's Name	Complete Name and Address of Treatment Facility or Physician	Date Last Treated	Reason for Treatment

☐ Yes ☐ No j. Do you have a valid Medical Marijuana Card?

☐ Yes ☐ No k. Has any added individual(s) ever been treated for, diagnosed by or consulted a physician, psychotherapist, counselor or any other provider, or had any indication(s) of having a drug dependency/habit? If "yes," please provide name(s) below:

Applicant's Name	Complete Name and Address of Treatment Facility or Physician	Date Last Treated	Reason for Treatment

 (Continued on page 3)

SECTION 6 | ADD PERSON(S) TO POLICY (continued)

☐ Yes ☐ No l. Has any added individual(s) required the assistance of any other individual for performances of any activities of daily living? If "yes," please provide name(s) below:

Applicant Name:	
Applicant Name:	

☐ Yes ☐ No m. Is any applicant currently a patient in a hospital or nursing home? If "Yes", please provide name(s) below:

Applicant Name:	
Applicant Name:	

Is any applicant **currently** taking any prescription medication, or has any applicant taken prescription medication in the last 3 years?
☐ Yes ☐ No

If you answered "Yes," please provide full details below. Use separate sheet if necessary. **Any attachment must include all of the same information requested here and must be signed and dated.** A printout from the pharmacy is **not** acceptable. **Please provide the name that would have been used at the time of the prescription — e.g., a maiden name may have been used.**

Person Treated	Name of Drug	Dosage	Specific Disorder or Illness	Start Date/ Stop Date		Complete Name and Address of Prescribing Physician
				mo	year	
				mo	year	

(Continued on page 4)

SECTION 6 | ADD PERSON(S) TO POLICY (continued)

MEDICAL CONDITIONS

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.

For each question checked below, give full details in the ADDITIONAL MEDICAL INFORMATION section which follows.
In the last 7 years, has any added individual(s) had or been told he/she had:

- ☐ Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related Complex (ARC) or Immune Deficiency Disorder or HIV
- ☐ Adrenal disorders
- ☐ Alzheimer's Disease or senile dementia
- ☐ Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
- ☐ Anemia
- ☐ Angina, heart attack, myocardial infarction
- ☐ Arteriosclerosis, atherosclerosis, Coronary Artery Disease, stent placement or angioplasty
- ☐ Attempted suicide
- ☐ Brain and nervous system disorders
- ☐ Cancer, Leukemia, or malignancy of any kind
- ☐ Cardiomyopathy, Enlarged Heart, Congestive Heart Failure
- ☐ Cerebral Palsy
- ☐ Cerebrovascular accident (stroke), including Transient Ischemic Attack (TIA)
- ☐ Chronic fatigue
- ☐ Chronic Obstructive Pulmonary Disease, emphysema, lung disease or Respiratory Syncytial Virus (RSV), sleep apnea
- ☐ Cirrhosis
- ☐ Connective Tissue disorder
- ☐ Crohn's Disease or ulcerative colitis
- ☐ Diabetes, abnormal glucose
- ☐ Dialysis
- ☐ Eyes, Ears, Nose or Throat disorders
- ☐ Fibromyalgia
- ☐ Gastric bypass surgery or other weight loss procedure
- ☐ Gastric or duodenal ulcer
- ☐ Glandular disorders
- ☐ Heart bypass surgery, pacemaker implant
- ☐ Heart or vein/artery surgery
  - ☐ Congenital ☐ Disease
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hodgkin's or Non-Hodgkin's Disease
- ☐ Hypertension
- ☐ Kidney, urinary or reproductive disorders
- ☐ Lupus, systemic
- ☐ Meniere's Disease
- ☐ Mental disorders
- ☐ Multiple Sclerosis, Muscular Dystrophy, or Myasthenia Gravis
- ☐ Musculoskeletal disorders
- ☐ Nephritis
- ☐ Nephrotic Syndrome, renal disease or failure
- ☐ Pancreatitis
- ☐ Parkinson's Disease
- ☐ Pending surgery
- ☐ Polyneuritis
- ☐ Respiratory, digestive, or circulatory condition
- ☐ Sarcoidosis
- ☐ Silicone breast implants
- ☐ Sugar, blood, or protein in urine
- ☐ Thyroid disorders
- ☐ Transplant recipient (except cornea/lens)
- ☐ Valve repair/replacement/shunts or stents/retained hardware
  - ☐ Congenital ☐ Disease
- ☐ Any injury, deformity, incapacitation, disease or condition not listed elsewhere
- ☐ Any symptoms, ailments or concerns needing medical evaluation

☐ **None of the above apply to any applicant(s)**

ADDITIONAL MEDICAL INFORMATION

Give full details to questions answered affirmatively (checked or answered "Yes") to explain answers to questions in SECTION 6. In addition to **condition/illness** please provide the **type of treatment** provided or planned – for example, surgery, X-rays, EKG, lab tests, hospitalization, emergency room visit, nursing home confinement, doctor visits, rehabilitation services, occupational therapy, physical therapy, speech therapy or chiropractic treatments. **Please ensure you include all the treatments that apply. Please use the name that would have been given at the time of the physician visit — e.g., a maiden name.**

Condition/Illness	Person Treated	Specific Disorder/ Illness	Type of Treatment	Frequency of treatment	Complete Name and Address of Physician

SECTION 6 | ADD PERSON(S) TO POLICY (continued)

PHYSICIAN INFORMATION

Applicant's Name	Complete Name and Address of Physician, Healthcare Provider, and/or Primary Care Physician	Date of Last Visit*	Reason for Last Visit (Condition, Rx, Treatment)

*Please write **NO VISIT** in this box if the applicant has never seen the physician.

HOUSEHOLD/RESIDENCY

☐Yes ☐No a. Do all the added individual(s) under the age of 18 reside in the same household? If "no," please provide reason and his/her name and address:

Name	
Address	
Reason	

☐Yes ☐No b. Are all the added individual(s) permanent, legal residents of Arkansas? If "no," please provide reason and his/her name and address:

Name	
Address	
Reason	

Additional information may be required.

☐Yes ☐No Are all applicants U.S. citizens? If "No", please provide the name(s) of the applicant(s) who are not U.S. citizens.

Name	

Type of Permanent Visa or Permanent Green Card

USCIS Category	Registration No.	Issue Date (Mo. Day Yr.)	Expiration Date (Mo. Day Yr.)

☐Yes ☐No Have all applicants applying for coverage resided in the U.S. for at least 12 continuous months? If "No", please provide the name(s) of the applicant(s) who have not resided in the U.S. for at least 12 continuous months.

Name	

☐Yes ☐No Do all applicants applying for coverage have a Primary Care Physician established in the U.S.? If "No", please provide the name(s) of the applicant(s) who do not have a Primary Care Physician established in the U.S.

Name	

TOBACCO USE

☐Yes ☐No Has any applicants to be covered used **any form of tobacco or nicotine supplements/cessation products** within the last 12 months? If "Yes," please provide the following:

Name	Date Last Used:

SECTION 7 | DELETE PERSON(S) FROM THE POLICY

In the event you would like to **terminate coverage** for a covered person, including the primary policyholder, you can do so by completing this section, **OR** you have the option to **maintain coverage on the person you would like to delete from your policy** by splitting him/her off onto a new individual policy with identical coverage. This will completely remove him/her from your coverage and create a new policy for the covered person. You can make this change by completing **Section 9 – Split Policy.** A signature is **required** by **both** the current policyholder and the person maintaining their coverage and moving to a new policy of their own.

Important Note: Complete one change form for each new policy you are requesting.

First Name	M.I.	Last Name	Suffix	Reason	Date of Event

SECTION 8 | OWNERSHIP CHANGE

Complete this section only when the primary policyholder is being removed. **Except for death of the primary policyholder, both the primary policyholder and the covered person maintaining the policy coverage and being moved to the new primary policyholder must sign the change form.**

	First Name	M.I.	Last Name
From:			
To:			

SECTION 9 | SPLIT POLICY

Indicate the name of the covered person(s) you want covered on a separate policy with identical coverage.

First Name	M.I.	Last Name	Suffix	Reason	Date of Event

Primary Phone Number	Alternate Phone Number	E-mail Address

Please provide address information for new Policyholder ONLY:

Residential

Street	City	State	County	Zip

Mailing

Street	City	State	County	Zip

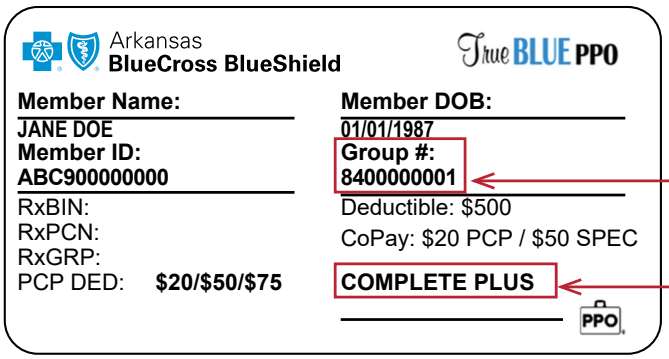
Billing

Street	City	State	County	Zip

SECTION 10 | BENEFIT CHANGES

- **Please complete only the section for your specific policy.**
- If you are unsure of your product name, use the product group numbers listed as a reference. Your product group number can be found on your identification card under **Group #.** It will be the first six numbers before the dash.
- If you still have questions, call customer service at **1-800-238-8379.**

SAMPLE IDENTIFICATION CARD



▸ COMPLETE

Deductible:

- ☐ $1,000 Individual/$2,000 Family
- ☐ $2,500 Individual/$5,000 Family
- ☐ $5,000 Individual/$10,000 Family
- ☐ $7,500 Individual/$15,000 Family

Coinsurance

- ☐ 20%
- ☐ 30%

- Single Term policies **CAN INCREASE** deductibles and coinsurance but **CANNOT DECREASE** deductibles or coinsurance.
- Renewable Term policies **CAN INCREASE** deductible and/or coinsurance at any time and **CAN DECREASE** deductibles or coinsurance after 12 months.

▸ COMPLETE PLUS

Deductible:

- ☐ $500 Individual/$1,000 Family
- ☐ $1,000 Individual/$2,000 Family
- ☐ $2,500 Individual/$5,000 Family
- ☐ $5,000 Individual/$10,000 Family

Coinsurance

- ☐ 20%

- Single Term policies **CAN INCREASE** but **CANNOT DECREASE** deductibles.
- Renewable Term policies **CAN INCREASE** deductibles at any time and **CAN DECREASE** deductibles after 12 months.

IMPORTANT NOTE: Increasing the deductible means that any claims processed by Arkansas Blue Cross after the effective date of change, regardless of the date of the service(s), will be applied to the new higher deductible.

SECTION 11 | POLICY SURCHARGE REVIEW

Can only be requested for Renewable Term policies after they have been in effect 24 months.

☐ Review Tobacco Surcharge	Name of Insured	Date Quit
☐ Review Other Surcharge	Name of Insured	

SECTION 12 | APPLICATION METHOD

Select one answer for each question below. Electronically includes via email, fax or online.

1. How was this application received or started?
   ☐ Phone ☐ Face-to-Face ☐ Electronically ☐ Mail
2. How was this application submitted or completed?
   ☐ Phone ☐ Face-to-Face ☐ Electronically ☐ Mail

(Continued on page 8)

PLEASE READ BEFORE SIGNING

I understand: (1) This application may be rejected if the applicant is age 18 or older. (2) This application will be medically underwritten in order to assess the potential financial risk of each individual on the application. As the result of the assessment, my application may be approved with no changes, approved but charged a higher premium, or I may be declined for coverage. (3) If accepted, the insurance applied for shall not become effective until the date shown on my schedule of benefits and the adjusted premium, if applicable, is paid in full. (4) 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 intentional misrepresentations of material fact or fraud. (5) My signature authorizes Arkansas Blue Cross and Blue Shield to coordinate benefits under this policy with other insurance I have which is subject to coordination. (6) 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 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.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I certify that I signed this change form in the state of Arkansas.

SIGNATURE SECTION | (Please sign appropriate line only)

Primary Applicant OR Parent/Legal Guardian **(if policy for a minor)**	Date Signed
Spouse **(required if applying)**	Date Signed
Dependent age 18 or older **(required if applying)**	Date Signed
Dependent age 18 or older**(required if applying)**	Date Signed

CUSTODIAL PARENT SECTION

If any applicant under age 18 (primary applicant or dependent), named on this application, does NOT reside with the policyholder indicated in Section 2, the custodial parent's signature is also required.

Custodial parent's name (please print)		**Phone number**	
Custodial parent's address (Street or PO box)	**City**	**State**	**ZIP**
Custodial parent's signature		**Date signed**	

THIS APPLICATION IS VALID FOR 45 DAYS ONLY WHEN COMPLETED AND SIGNED.

RETURN INSTRUCTIONS

- Any **attachments** submitted with the change form must be signed and dated.
- Do not send any money with this change form.
- **Please ensure all required parties have signed and dated the change form prior to submission.**
- We strongly recommend you make a copy of this completed change form for your records.

P.O. Box 2181, Little Rock, AR 72203-2181

PRE-AUTHORIZED BANK DRAFT | Monthly Program Sign-up Form

Our monthly bank draft service makes premium payments easy and convenient for you. Just a few steps now help assure your payments are made accurately and timely.

1. **Complete the information below.**
2. **Mail this completed authorization form to:**

   Arkansas Blue Cross and Blue Shield
   Attn: Cashiers (Drafts)
   P.O. Box 3590
   Little Rock, AR 72203

IMPORTANT: Please read before signing

I authorize Arkansas Blue Cross and Blue Shield, USAble Life, and the BANK indicated below, to debit my Arkansas Blue Cross and/or USAble Life 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 and/or USAble Life coverage, UNLESS Arkansas Blue Cross and/or USAble Life 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.

Insured's Information

First Name	Last Name

Street address	Apt. No.	City	State	Zip

Arkansas Blue Cross and Blue Shield Member ID

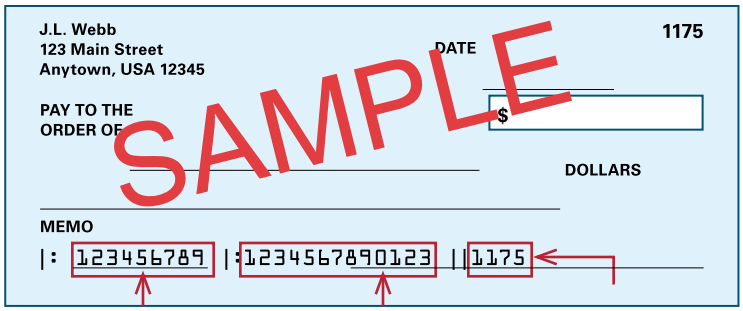
Please check one of the following:

☐ Currently, the insured's premium is **not** drafted. ☐ Currently, the insured's premium is drafted and the account information has changed.

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 of Bank Account Holder	Date

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!

For Office Use Only (please do not write in this space)

ID NO.	EFFECTIVE DATE

Arkansas
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USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products. USAble Life is solely responsible for the term life and critical illness policies referenced in your policy.

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