

UNIVERSITY OF ARKANSAS GROUP BENEFITS CHANGE FORM

Campus: UAASMSA UACCB UACES UAF UALR UAMS UAM UAPB OTHER_____

| EMPLOYEE LAST NAME | FIRST NAME | MI | BIRTHDATE | SEX | SOC SEC NO |
|--------------------|------------|----|-----------|-----|------------|
| | | | | | |

NAME CHANGE: FROM: _____ **EFFECTIVE DATE:** _____

OPTIONAL LIFE

| | | |
|--|---|-----------------------|
| <input type="checkbox"/> ADD <input type="checkbox"/> 1X <input type="checkbox"/> 2X <input type="checkbox"/> 3X <input type="checkbox"/> 4X ~CANCEL COVERAGE | <input type="checkbox"/> EVIDENCE OF INSURABILITY COMPLETED | EFFECTIVE DATE: _____ |
| <input type="checkbox"/> INCREASE FROM _____ TO _____ <input type="checkbox"/> DECREASE FROM _____ TO _____ | <input type="checkbox"/> EVIDENCE OF INSURABILITY COMPLETED | EFFECTIVE DATE: _____ |

DEPENDENT LIFE

| | | |
|--|---|-----------------------|
| <input type="checkbox"/> ADD AMOUNT _____ <input type="checkbox"/> CANCEL COVERAGE | <input type="checkbox"/> EVIDENCE OF INSURABILITY COMPLETED | EFFECTIVE DATE: _____ |
| <input type="checkbox"/> INCREASE FROM _____ TO _____ <input type="checkbox"/> DECREASE FROM _____ TO _____ | <input type="checkbox"/> EVIDENCE OF INSURABILITY COMPLETED <input type="checkbox"/> REASON: _____ | EFFECTIVE DATE: _____ |

OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT

| | |
|---|---|
| <input type="checkbox"/> ADD EMPLOYEE ONLY COVERAGE <input type="checkbox"/> ADD FAMILY COVERAGE <input type="checkbox"/> CANCEL COVERAGE | COVERAGE AMOUNT _____ EFFECTIVE DATE _____ EFFECTIVE DATE _____ |
| <input type="checkbox"/> INCREASE FROM _____ TO _____ <input type="checkbox"/> DECREASE FROM _____ TO _____ | <input type="checkbox"/> EMPLOYEE COVERAGE OF \$ _____ <input type="checkbox"/> FAMILY COVERAGE OF _____ |

OPTIONAL LONG TERM DISABILITY

| | | |
|--|--|-----------------------|
| <input type="checkbox"/> ADD <input type="checkbox"/> CANCEL COVERAGE | <input type="checkbox"/> SALARY ELIGIBILITY OF \$20,000 <input type="checkbox"/> EVIDENCE OF INSURABILITY COMPLETED | EFFECTIVE DATE: _____ |
|--|--|-----------------------|

BENEFICIARY CHANGES

List below the individual(s) you designate to receive proceeds from your Basic Life Insurance, Optional Life Insurance (if elected), and Optional Accidental Death & Dismemberment insurance (if elected). Unless otherwise indicated, payment will be made equally to all persons named. If no beneficiary is living at the time of distribution, payment will be made according to the policy terms. This supersedes any other beneficiary designation. The employee is the beneficiary of all dependent death benefits. (If space is needed for additional beneficiary designations, please use a separate page and attach.

P=Primary S=Secondary / B=Basic O=Optional A=Accidental Death & Dismemberment

| NAME (Last, First, MI) | SEX | RELATIONSHIP | P/S OR % | BENEFIT CODES |
|------------------------|-----|--------------|----------|---|
| | | | | <input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> AD&D |
| | | | | <input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> AD&D |
| | | | | <input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> AD&D |

EMPLOYEE SIGNATURE: _____ **Date:** _____

BENEFITS REPRESENTATIVE: _____ **Date:** _____

COPY DISTRIBUTION: WHITE - Human Resources Yellow - Employee