

# University of Arkansas Group Benefits Change Form

For Use at these UA Campuses Only:  PCCUA  UAM  UAPB

Last Name	First Name	M.I.	Birth Date	Sex	Employee I.D. Number
Name Change: From: _____ To: _____ Effective Date: _____					
<b>Optional Life</b>					
<input type="checkbox"/> Add <input type="checkbox"/> 1X <input type="checkbox"/> 2X <input type="checkbox"/> 3X <input type="checkbox"/> 4X <input type="checkbox"/> Cancel Coverage		<input type="checkbox"/> Evidence of Insurability Complete		Effective Date: _____	
<input type="checkbox"/> Increase From _____ to _____ <input type="checkbox"/> Decrease From _____ to _____		<input type="checkbox"/> Evidence of Insurability Complete		Effective Date: _____	
<b>Dependent Life</b>					
<input type="checkbox"/> Add Amount _____ <input type="checkbox"/> Cancel Coverage		<input type="checkbox"/> Evidence of Insurability Complete		Effective Date: _____	
<input type="checkbox"/> Increase From _____ to _____ <input type="checkbox"/> Decrease From _____ to _____		<input type="checkbox"/> Evidence of Insurability Complete		Effective Date: _____	
<b>Optional Accidental Death and Dismemberment</b>					
<input type="checkbox"/> Add Employee only Coverage <input type="checkbox"/> Add Family Coverage <input type="checkbox"/> Cancel Coverage		Coverage Amount _____ Employee Coverage Amount _____		Effective Date: _____	
<input type="checkbox"/> Increase From _____ to _____ <input type="checkbox"/> Decrease From _____ to _____		<input type="checkbox"/> Employee Coverage <input type="checkbox"/> Family Coverage		Effective Date: _____	
<b>Optional Long Term Disability</b>					
<input type="checkbox"/> Add <input type="checkbox"/> Cancel Coverage		<input type="checkbox"/> Salary Eligibility of \$20,000		Effective Date: _____	
<b>Beneficiary Changes</b>					
<p>List below the individual(s) you designate to receive proceeds from your Basic Life Insurance, Optional Life Insurance (if elected), and Optional Accidental Death &amp; 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>					
P = Primary   S = Secondary   B = Basic   O = Optional   A = Accidental Death & Dismemberment					
Name (Last, First, M.I.)		Sex	Relationship	P/S or %	Benefit Codes
					<input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> A
					<input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> A
					<input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> A
					<input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> A
Employee Signature:				Date:	
Benefits Representative:				Date:	