

Health Insurance Enrollment Application

(PLEASE PRINT FIRMLY – USE BALL POINT PEN)

TYPE OF REQUEST (Check all appropriate boxes that apply; additional documentation may be required)

NEW ENROLLMENT:
PICK A PLAN: Classic Plan Premier Plan Health Savings Plan (For the Health Savings Plan, a separate HSA enrollment form is required)
(If no box checked, default is Classic)
COVERAGE FOR: Employee Employee & Spouse* Employee & Child(ren) Employee, Spouse & Child(ren)
 I understand that any change I need to make to my health insurance benefits can only take place within 31 days of a qualify change of status event, in accordance with Section 125 regulations.

ADD FAMILY TO EXISTING COVERAGE*: Add Spouse Add Child(ren) under age 26

REMOVE FAMILY MEMBER(S): Drop Spouse Drop Child(ren)

TERMINATE ALL COVERAGE **CHANGE NAME/ADDRESS**

EMPLOYEE INFORMATION

1. NAME-LAST	FIRST	INITIAL	2. SOCIAL SECURITY NUMBER	3. DATE OF EMPLOYMENT
4. MAILING ADDRESS		CITY	STATE	ZIP CODE
5. HOME PHONE NO. ()	WORK PHONE NO. ()	6. MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED		7. EMAIL ADDRESS

MEMBER DATA (COMPLETE THIS SECTION FOR YOURSELF AND DEPENDENTS YOU WANT TO ADD OR DROP. IF MORE THAN THREE DEPENDENTS, ADD SECOND FORM)

8.	LAST NAME	FIRST NAME	INITIAL	9. SOC. SEC. NO. OR ALTERNATIVE NUMBER IS REQUIRED.	10. GENDER (circle one)	11. BIRTHDATE (month/day/year)	12. RELATIONSHIP
S E L F				____ - ____ - ____	M or F	___ / ___ / ____	Self
S P O U S E				____ - ____ - ____	M or F	___ / ___ / ____	Spouse
D E P 1				____ - ____ - ____	M or F	___ / ___ / ____	<input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other _____
D E P 2				____ - ____ - ____	M or F	___ / ___ / ____	<input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other _____
D E P 3				____ - ____ - ____	M or F	___ / ___ / ____	<input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other _____

12. IS YOUR SPOUSE EMPLOYED? YES NO IF YES, PLEASE INDICATE EMPLOYER ADDRESS _____
 NAME OF EMPLOYER _____ TELEPHONE _____

13. DO YOU OR ANY OF YOUR DEPENDENTS HAVE OTHER GROUP MEDICAL COVERAGE: YES NO IF YES, IS COVERAGE SINGLE OR FAMILY
 IF YES, NAME OF INSURANCE CARRIER(S): _____ POLICY NUMBER: _____

NAME OF INSURED: _____ DATE OF BIRTH _____ EFFECTIVE DATE OF COVERAGE _____ TERMINATION DATE OF COVERAGE _____

FAMILY MEMBERS COVERED AND RELATIONSHIP:

14. ARE YOU OR ANY OF YOUR DEPENDENTS ELIGIBLE FOR MEDICARE? YES NO

YES, NAME(S) _____	HEALTH INS. NO. _____	PART A-HOSPITAL EFFECTIVE DATE _____	PART B-MEDICAL EFFECTIVE DATE _____
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SIGNATURE

15. I apply for enrollment in the University of Arkansas group health plan for the persons listed above and agree that my family members and I shall be covered according to the terms of the plan. Any person who knowingly presents a false or fraudulent claim payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines, confinement in prison and termination of employment.

I hereby authorize deductions from my earnings of any required contributions. To the best of my knowledge and belief, all statements and answers to the questions on this application are complete and true, and I agree that the statements will be the basis of the insurance coverage. I agree to notify my Human Resources office and/or UMR promptly, in writing, concerning any changes in the above information.

Employee Signature Date

FOR EMPLOYER/OFFICE USE

CAMPUS: UA Walton Center UA Foundation WRI

EFFECTIVE DATE _____ UACCB UAFA UAM UAPTC UAPB PCCUA

DATE OF CHANGE _____ Other _____ EIN-760003452-NEW HIRE NOTICE

REASON FOR CHANGE _____ DOCUMENTATION YES NO