GROUP BENEFITS ENROLLMENT FORM

HR USE ONLY: Date Employee Became Eligible for Benefits:

Please complete all sections of this form. If you elect pre-tax contributions for any group benefits (medical, dental, vision, The Standard, or AFLAC), you may not change that benefit until the next election period unless you have a change in family status. Return the completed form to Human Resources.

SSN	**FULL LEGAL NAME: Last First Middle Suffix**			**Birthdate**
Address		**City**	**State**	**Zip Code**
Date of Hire	**Gender:** M / F	**Marital Status:** ___ Single ___ Married	**Employment Status:** ___ 12-Month ___ 11-Month ___10 ½-Month ___ 9-Month ___ Other	

MEDICAL PLAN	___ Enrolled (Completed UMR enrollment form) ___ Decline – Currently, I have other medical coverage, therefore I choose to decline coverage at the present time. I understand that I may not have another opportunity to enroll unless I have a qualifying event in which case I have 31 days from the event to enroll. ___ Decline for other reasons.	___ Decline Coverage
DENTAL PLAN	___ Enrolled (Completed BCBS Dental enrollment form)	___ Decline Coverage
VISION PLAN	___ Enrolled (Completed Superior Vision enrollment form)	___ Decline Coverage
CRITICAL ILLNESS	___ Enrolled (Completed Critical Illness enrollment form)	___ Decline Coverage
OPTIONAL AD&D	You may choose coverage for yourself in $25,000 increments (max of $300,000) not to exceed 15 times your annual salary. Family coverage pays benefits for your spouse at 60% of employee amount and each child at 20%. ___ Enrolled (Completed The Standard enrollment form)	___ Decline Coverage
OPTIONAL LIFE INSURANCE	This is in addition to the Basic Life Insurance provided by the University, and the maximum benefit is $500,000. ___ Enrolled (Completed The Standard enrollment form)	___ Decline Coverage
DEPENDENT LIFE INSURANCE	You may also purchase dependent life coverage on your eligible dependents. Each child is covered for 50% of the spouse amount elected. ___ Enrolled (Completed The Standard enrollment form)	___ Decline Coverage
OPTIONAL LTD	This is available to employees with salaries over $20,000 in addition to the Basic LTD provided by the University. ___ Enrolled (Completed The Standard enrollment form)	___ Decline Coverage
OPTIONAL STD	This is available to employees with salaries over $20,000 in addition to the Basic STD provided by the University. ___ Enrolled (Completed The Standard enrollment form)	___ Decline Coverage

AUTHORIZATION – I have read enrollment materials, completed enrollment forms, and understand the benefit elections I made on this form. I had the opportunity to accept or decline coverage. I have been informed about my benefit options and understand the effective dates, coverage and premiums. I understand that if I elect family or dependent coverage under any University plan, I may not be covered both as an employee and as a dependent under another University of Arkansas System employee's plan; and that dependent children may be covered only under one parent's plan, but not both. I understand I have 31 days from my date of hire to make a decision concerning my benefit elections, and I can change my benefit elections at any time during my first 31 days of employment. I understand that the timing of my elections can result in premiums being doubled up in a single pay period. I understand my completed application must be received by Human Resources within 31 days of hire. If I gain a dependent through marriage, birth, adoption, or placement for adoption, I may enroll myself, my spouse and dependent(s) within 31 days. I have been given the opportunity to ask questions and I understand I may call or visit Human Resources if I have any future questions or concerns. I authorize my employer to deduct from my wages or salary the amount of contributions, if any, required for the benefits I have selected.

EMPLOYEE SIGNATURE ____ DATE _________________________

HR REPRESENTATIVE ____ DATE _________________________

Revised 10/2020