

UNIVERSITY OF ARKANSAS GROUP BENEFITS CHANGE FORM

Campus: OUAF OUALR OUAM OUAMS OUAPB OUA SYSTEM OCES

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"/> 01X <input type="checkbox"/> 02X <input type="checkbox"/> 03X <input type="checkbox"/> 04X <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	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 AMOUNT _____ <input type="checkbox"/> CANCEL COVERAGE	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

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
				<input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> AD&D

EMPLOYEE SIGNATURE: _____	DATE: _____
BENEFITS REPRESENTATIVE: _____	DATE: _____