UNIVERSITY OF ARKANSAS GROUP BENEFITS CHANGE FORM

Campus: ASMSA UACCB UACES UAF UALR UAMS UAM UAPB OTHER

<table>
<thead>
<tr>
<th>EMPLOYEE LAST NAME</th>
<th>FIRST NAME</th>
<th>MI</th>
<th>BIRTHDATE</th>
<th>SEX</th>
<th>SOC SEC NO or ID NUMBER</th>
</tr>
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NAME CHANGE: FROM:______________________ TO:______________________ EFFECTIVE DATE:______________________

ADDRESS CHANGE:__________________________________________________________

OPTIONAL LIFE

☐ ADD 1X ☐ 2X ☐ 3X ☐ 4X
☐ INCREASE FROM_____ TO_____
☐ DECREASE FROM_____ TO_____
☐ CANCEL COVERAGE

☐ EVIDENCE OF INSURABILITY COMPLETED* EFFECTIVE DATE:______________________
*Not required for decreases or cancellations.

DEPENDENT LIFE

☐ ADD AMOUNT________
☐ INCREASE FROM______ TO________
☐ DECREASE FROM______ TO________
☐ CANCEL COVERAGE

☐ EVIDENCE OF INSURABILITY COMPLETED* EFFECTIVE DATE:______________________
*Not required for decreases or cancellations.

REASON:______________________________

OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT

☐ ADD EMPLOYEE ONLY COVERAGE
☐ ADD FAMILY COVERAGE
☐ INCREASE FROM______ TO________
☐ DECREASE FROM______ TO________
☐ CANCEL COVERAGE

☐ EMPLOYEE COVERAGE OF $_______________ EFFECTIVE DATE:______________________

☐ FAMILY COVERAGE OF $_______________

OPTIONAL SHORT TERM DISABILITY

☐ ADD
☐ CANCEL COVERAGE

☐ SALARY ELIGIBILITY OF $45,000 (CLASSIFIED ONLY) EFFECTIVE DATE:______________________

☐ POSITION CHANGE FROM CLASSIFIED TO NONCLASSIFIED

☐ LATE ENROLLMENT (more than 31 days from appointment date. Late Entrant Penalty applies)

OPTIONAL LONG TERM DISABILITY

☐ ADD
☐ CANCEL COVERAGE

☐ SALARY ELIGIBILITY OF $20,000 EFFECTIVE DATE:______________________

☐ LATE ENROLLMENT (more than 31 days from appt date. 12-month pre-existing period applies)

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.

<table>
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<tr>
<th>P=Primary</th>
<th>S=Secondary</th>
<th>B=Basic</th>
<th>O=Optional</th>
<th>A=Accidental Death &amp; Dismemberment</th>
<th>BENEFIT CODES</th>
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<tr>
<td>NAME (Last, First, MI)</td>
<td>SEX</td>
<td>RELATIONSHIP</td>
<td>P/S OR %</td>
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EMPLOYEE SIGNATURE:____________________________________ Date:______________________

BENEFITS REPRESENTATIVE:__________________________________________ Date:______________________

GB/CHANGE DECEMBER 2014 UACES003