UNIVERSITY OF ARKANSAS

Division of Finance and Administration
Office of Human Resources

UNIVERSITY OF ARKANSAS
Election to TERMINATE
HEALTH, DENTAL and/or VISION Coverage Form

EMPLOYEE NAME	SOCIAL SECURITY NUMBER

Effective 12/31/2018, I elect to voluntarily terminate my University of Arkansas HEALTH, DENTAL and/or VISION coverage and elect to have any payroll deductions stopped. Check only those plans you wish to cancel.

- ☐ **Cancel Medical Coverage Election:** I elect to cancel my Medical Coverage and Premiums. I understand I will not be able to re-enroll for coverage at a later date without a qualified family change or a HIPAA event as described in the UA Medical Summary Plan Description.

- ☐ **Cancel Dental Coverage Election:** I elect to cancel my Dental Coverage and Premiums. I understand I will not be able to re-enroll for coverage at a later date without a qualified family change or a HIPAA event as described in the UA Dental Summary Plan Description.

- ☐ **Cancel Vision Insurance Election:** I elect to cancel my Vision Coverage and Premiums. I understand I will not be able to re-enroll for coverage at a later date except during a future plan Open Enrollment.

Employee Signature _____ Date _____