UNIVERSITY OF ARKANSAS (UAF) GROUP BENEFITS ENROLLMENT FORM

I am a Transfer from: ☐UACCB ☐UACES ☐UALR ☐ASMSA ☐UAMS ☐UAM ☐UAPB ☐OTHER_____

To be completed by Human Resources Department: Effective Date _____

Please complete all sections of this form. Remember, if you elect pre-tax contributions, you may not change your medical, dental or vision elections until the next election period unless you have a change in family status. Return the completed form to your Human Resources Department. **PLEASE PRINT CLEARLY.**

Social Security Number	Last Name	First Name	MI	Date of Birth

Address	City	State	Zip Code

Date of Hire or Appointment	Department or Location	Sex (M/F)	Marital Status: ☐ Single ☐ Married	Employment Status: ☐9-month ☐10-month ☐10 2-month ☐12-month

Medical Plan	☐ Enrolled (Complete UMR enrollment form) ☐ Decline - Currently, I have other medical coverage, therefore, I chose to decline coverage at the present time. If I or my dependent(s) should lose current coverage, I understand that I have 31 days to enroll in the UA Medical Plan. I understand that in order to be able to enroll upon a loss of coverage, (1) I must decline because of other coverage (2) the loss of other coverage includes a loss as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment or termination of employer contributions towards the other coverage. Loss of eligibility does not include a loss due to failure to pay premiums on a timely basis or termination of other coverage for cause. ☐ Decline for other reasons	☐ No coverage
Dental Plan	☐ Enrolled (Complete Arkansas Blue Cross Blue Shield enrollment form)	☐ No coverage
Vision	☐ Enrolled (Complete Superior Vision enrollment form)	☐ No coverage
Your Contribution	Check which of your eligible contributions you would like to pay on a pre-tax basis under Section 125. ☐ Medical ☐ Dental ☐ Vision	☐ None
Optional Accidental Death & Dismemberment	You may choose coverage for yourself in $25,000 increments (maximum 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%. ☐ Employee coverage of $ _____ ☐ Family coverage	☐ No coverage
Optional Life Insurance	This is in addition to the Basic Life Insurance provided by the University, and the maximum benefit is $500,000. ☐ 1 X annual salary ☐ 2 X annual salary ☐ 3 X annual salary ☐ 4 X annual salary	☐ No 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 below. (Children ages 14 days-6 months are covered for $1,000) ☐ $10,000 ☐ $15,000 ☐ $20,000	☐ No coverage
Optional Long Term Disability	This is available to employees with salaries over $20,000 in addition to the Basic Long Term Disability provided by the University. ☐ 60% of salary (maximum monthly benefit of $5,000)	☐ No coverage ☐ Not eligible
Optional Short Term Disability ***Division of Agriculture employees not eligible***	**For Classified Staff.** Covers salary greater than $45,000 up to a maximum benefit of $2,492 per week. ☐ 60% of salary **For Non-Classified Faculty/Staff.** Covers salary up to a maximum benefit of $2,492 per week. ☐ 60% of salary	☐ No coverage

BENEFICIARIES - 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 separate page and attach.)

P = PRIMARY **S** = SECONDARY / **B** = BASIC **O** = OPTIONAL **AD&D** = OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT

NAME (Last, First, Middle)	SEX (M/F)	DATE OF BIRTH	RELATIONSHIP	P/S OR %	BENEFIT CODES
					☐ B ☐ O ☐ AD&D
					☐ B ☐ O ☐ AD&D
					☐ B ☐ O ☐ AD&D
					☐ B ☐ O ☐ AD&D

AUTHORIZATION - I have read the enrollment materials and understand the benefit selections and beneficiary designations I have made on this form. I have had the opportunity to accept or decline coverage. I have been informed about my fringe benefit options, and I 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 employee's plan and that dependent children may be covered only under one parents plan but not both. I understand I have 31 days from my date of hire to make decisions concerning my benefit elections, and I can change my benefit elections at any time during my first 31 days of employment. I understand my application must be received by Human Resources within 31 days of hire. If I do not elect life and/or disability coverage within 31 days of hire, I (along with my eligible spouse and/or dependents) will be subject to evidence of insurability requirements. I understand I cannot choose medical and/or dental coverage after 31 days of hire unless I have a qualified family status change or qualified loss of other coverage. 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 my Human Resources Office 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: _____

BENEFITS REPRESENTATIVE _____ DATE:_____