

Health Insurance Enrollment Application

(PLEASE PRINT FIRMLY – USE BALL POINT PEN)

TYPE OF REQUEST (Check all appropriate boxes that apply; additional documentation may be required)

NEW ENROLLMENT:

PICK A PLAN: Classic Plan Premier Plan Health Savings Plan (For the Health Savings Plan, a separate HSA enrollment form is required)
(If no box checked, default is Classic)

COVERAGE FOR: Employee Employee & Spouse* Employee & Child(ren) Employee, Spouse & Child(ren)

PREMIUM DEDUCTION: Pre-tax Post-tax (if no box checked, default is Post-tax)

ADD FAMILY TO EXISTING COVERAGE*: Add Spouse Add Child(ren) under age 26

REMOVE FAMILY MEMBER(S): Drop Spouse Drop Child(ren)

TERMINATE ALL COVERAGE

CHANGE NAME/ADDRESS

EMPLOYEE INFORMATION

1. NAME-LAST	FIRST	INITIAL	2. SOCIAL SECURITY NUMBER	3. DATE OF EMPLOYMENT
4. MAILING ADDRESS		CITY	STATE	ZIP CODE
5. HOME PHONE NO. ()	WORK PHONE NO. ()	6. MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED		7. EMAIL ADDRESS

MEMBER DATA (COMPLETE THIS SECTION FOR YOURSELF AND DEPENDENTS YOU WANT TO ADD OR DROP. IF MORE THAN THREE DEPENDENTS, ADD SECOND FORM)

8. LAST NAME	FIRST NAME	INITIAL	9. SOC. SEC. NO. OR ALTERNATIVE NUMBER IS REQUIRED.	10. GENDER (circle one)	11. BIRTHDATE (month/day/year)	12. RELATIONSHIP
SELF			___ - ___ - _____	M or F	___ / ___ / _____	Self
SPOUSE			___ - ___ - _____	M or F	___ / ___ / _____	Spouse
DEP 1			___ - ___ - _____	M or F	___ / ___ / _____	<input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other _____
DEP 2			___ - ___ - _____	M or F	___ / ___ / _____	<input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other _____
DEP 3			___ - ___ - _____	M or F	___ / ___ / _____	<input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other _____

12. IS YOUR SPOUSE EMPLOYED? YES NO IF YES, PLEASE INDICATE EMPLOYER ADDRESS _____ TELEPHONE _____

13. DO YOU OR ANY OF YOUR DEPENDENTS HAVE OTHER GROUP MEDICAL COVERAGE: YES NO IF YES, IS COVERAGE SINGLE OR FAMILY
IF YES, NAME OF INSURANCE CARRIER(S): _____ POLICY NUMBER: _____

NAME OF INSURED: _____ DATE OF BIRTH _____ EFFECTIVE DATE OF COVERAGE _____ TERMINATION DATE OF COVERAGE _____

FAMILY MEMBERS COVERED AND RELATIONSHIP:

14. ARE YOU OR ANY OF YOUR DEPENDENTS ELIGIBLE FOR MEDICARE? YES NO
YES, NAME(S) _____ HEALTH INS. NO. _____ PART A-HOSPITAL EFFECTIVE DATE _____ PART B-MEDICAL EFFECTIVE DATE _____

SIGNATURE

15. I apply for enrollment in the University of Arkansas group health plan for the persons listed above and agree that my family members and I shall be covered according to the terms of the plan. Any person who knowingly presents a false or fraudulent claim payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines, confinement in prison and termination of employment.

I hereby authorize deductions from my earnings of any required contributions. To the best of my knowledge and belief, all statements and answers to the questions on this application are complete and true, and I agree that the statements will be the basis of the insurance coverage. I agree to notify my Human Resources office and/or UMR promptly, in writing, concerning any changes in the above information.

Employee Signature _____ Date _____

FOR EMPLOYER/OFFICE USE

EFFECTIVE DATE _____

DATE OF CHANGE _____

REASON FOR CHANGE _____

CAMPUS: ASMSA CES UAF Criminal Justice UA Foundation UA Walton Center
 UACCB UALR UAM UAMS UAPB WRI PCCUA UA FS UAPulaski Tech
 Other _____ EIN-760003452-NEW HIRE NOTICE

DOCUMENTATION YES NO

Dependent Verification for Insurance Coverage

***Documentation must be provided if you wish to add a spouse or dependent child to your health, dental or vision coverage.**

Coverage can be added within one month (31 days max) of: 1) initial eligibility as a new hire, 2) a change in status to benefits-eligible, 3) a qualifying life event; or 4) during an announced open enrollment period. Enrollment is effective within the next available coverage start date – generally the first of the following month – and is not retroactive (exception for newborns).

All supporting documentation as described below must be submitted at the time of enrollment. Benefit enrollment forms to enroll dependents will not be accepted if documentation is not provided. Therefore you may be required to re-complete forms for “employee only” coverage initially, with the option to revise your enrollment within 31 days.

This certifies that all dependents covered under my health, dental or vision insurance are my legal dependents as defined below. I understand that insurance fraud is generally defined as the “intentional misrepresentation of material facts and circumstances to an insurance company to obtain payment that would not otherwise be made” and disciplinary action will be taken, up to and including termination of employment, should this occur. In addition, I understand I will be held liable for any claims or fees incurred for the individual that is not a dependent.

Signature of Employee

Soc. Sec. Number or ID #

Date

Documentation Provided Includes:

Send fully legible photocopies only, not originals. Commemorative certificates and un-recorded documents are NOT acceptable.

Proof for Legal Spouse

- Marriage License that is government-issued and signed by the country clerk, state registrar or other assigned government official. Must carry the seal of that office documenting the license has been recorded.

Proof for Dependent Child under age 26

- Biological Child: government-issued Birth Certificate identifying you as the parent
- Newborn Child less than 31 days old: hospital issued Birth Certificate may be accepted if the document includes each of the following: newborn’s name, parent’s name, date of birth, and signature of the attending physician and/or hospital administration.
- Step-Child: government-issued Birth Certificate identifying your spouse as a parent AND a government-issued Marriage License showing you are married to the parent
- Adopted Child: court document showing adoption placement, petition for adoption or final adoption certificate; date of birth must be included
- Legal Ward/Guardian Child/Foster Child under age 18: court or agency documentation AND a government-issued Birth Certificate
- Medical Support Court Order: court documentation ordering you to provide insurance for your biological child
- Adult Disabled Child: government-issued Birth Certificate identifying you as the parent AND medical certification of disability prior to age 26. If the adult disabled child is your step-child, a government-issued Marriage License showing you are married to the parent is also required.