

UNIVERSITY OF ARKANSAS GROUP BENEFITS CHANGE FORM

Campus: ASMSA UACCB UACES UAF UALR UAMS UAM UAPB OTHER_____

EMPLOYEE LAST NAME	FIRST NAME	MI	BIRTHDATE	SEX	SOC SEC NO or ID NUMBER

NAME CHANGE: FROM: _____ TO: _____ EFFECTIVE DATE: _____

ADDRESS CHANGE: _____

OPTIONAL LIFE

<input type="checkbox"/> ADD <input type="checkbox"/> 1X <input type="checkbox"/> 2X <input type="checkbox"/> 3X <input type="checkbox"/> 4X <input type="checkbox"/> INCREASE FROM _____ TO _____ <input type="checkbox"/> DECREASE FROM _____ TO _____ <input type="checkbox"/> CANCEL COVERAGE	<input type="checkbox"/> EVIDENCE OF INSURABILITY COMPLETED* <i>*Not required for decreases or cancellations.</i>	EFFECTIVE DATE: _____
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DEPENDENT LIFE

<input type="checkbox"/> ADD AMOUNT _____ <input type="checkbox"/> INCREASE FROM _____ TO _____ <input type="checkbox"/> DECREASE FROM _____ TO _____ <input type="checkbox"/> CANCEL COVERAGE	<input type="checkbox"/> EVIDENCE OF INSURABILITY COMPLETED* <i>*Not required for decreases or cancellations.</i> <input type="checkbox"/> REASON: _____	EFFECTIVE DATE: _____
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OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT

<input type="checkbox"/> ADD EMPLOYEE ONLY COVERAGE <input type="checkbox"/> ADD FAMILY COVERAGE <input type="checkbox"/> INCREASE FROM _____ TO _____ <input type="checkbox"/> DECREASE FROM _____ TO _____ <input type="checkbox"/> CANCEL COVERAGE	<input type="checkbox"/> EMPLOYEE COVERAGE OF \$ _____ <input type="checkbox"/> FAMILY COVERAGE OF \$ _____	EFFECTIVE DATE: _____
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OPTIONAL SHORT TERM DISABILITY

<input type="checkbox"/> ADD <input type="checkbox"/> CANCEL COVERAGE	<input type="checkbox"/> SALARY ELIGIBILITY OF \$45,000 (CLASSIFIED ONLY) <input type="checkbox"/> POSITION CHANGE FROM CLASSIFIED TO NONCLASSIFIED <input type="checkbox"/> LATE ENROLLMENT (more than 31 days from appointment date. Late Entrant Penalty applies)	EFFECTIVE DATE: _____
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OPTIONAL LONG TERM DISABILITY

<input type="checkbox"/> ADD <input type="checkbox"/> CANCEL COVERAGE	<input type="checkbox"/> SALARY ELIGIBILITY OF \$20,000 <input type="checkbox"/> LATE ENROLLMENT (more than 31 days from appt date. 12-month pre-existing period applies)	EFFECTIVE DATE: _____
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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: _____