

# Health Insurance Enrollment Application

Benefits administered by:  
United Medical Resources-Enrollment Services  
PO Box 8052, Wausau, WI 54402-8052

(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 ☐ Point of Service Plan  
**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 (fill out items 8-17 below)  
**REMOVE FAMILY MEMBER(S):** ☐ Drop Spouse ☐ Drop Child(ren) (fill out items 8-11 below)  
**TERMINATE ALL COVERAGE** **CHANGE NAME/ADDRESS**

## EMPLOYEE INFORMATION

1. NAME-LAST	FIRST	INITIAL	2. SOCIAL SECURITY NO.	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, IF MORE THAN THREE DEPENDENTS, USE SEPARATE FORM)

8. LAST NAME	FIRST NAME	INITIAL	9. SEX (M/F)	10. BIRTHDATE MO DA YR	11. RELATIONSHIP	12. LIST A PRIMARY CARE PHYSICIAN FROM THE DIRECTORY FOR EACH MEMBER BELOW	13. PROVIDER ID NO. (Not Phone Number)	14. CURRENT PATIENT (Y/N)
SELF						PCP		
SPOUSE						PCP		
DEP 1					<input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other	PCP		
DEP 2					<input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other	PCP		
DEP 3					<input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other	PCP		

15. IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO IF YES, PLEASE INDICATE ADDRESS \_\_\_\_\_  
NAME OF EMPLOYER \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
16. 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 OF COVERAGE \_\_\_\_\_  
FAMILY MEMBERS COVERED AND RELATIONSHIP: \_\_\_\_\_  
17. 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

18. 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  
☐ Other \_\_\_\_\_ ☐ EIN-760003452-NEW HIRE NOTICE  
DOCUMENTATION ☐ YES ☐ NO