

University of Arkansas
Medical Coverage Change of Election Form
Pine Bluff Campus

EMPLOYEE NAME	SOCIAL SECURITY NO.

I elect to change my medical care coverage option. Effective January 1, 20____, I wish my coverage to be:

- ☐ CLASSIC PLAN
- ☐ POINT-OF-SERVICE PLAN
- ☐ POINT-OF-SERVICE ALTERNATE PLAN (for out-of-state employees/retirees only)

PRIMARY CARE PHYSICIAN DESIGNATION

	LAST NAME	FIRST NAME	INITIAL	SEX (M/F)	BIRTH DATE Mo/Day/Yr	RELATION- SHIP	LIST NAME & NUMBER OF PRIMARY CARE PHYSICIAN FROM THE DIRECTORY FOR EACH MEMBER	PHYSICIAN NO.	CURRENT PATIENT (Y/N)
SELF							PCP		
	SOC SEC NO								
SPOUSE							PCP		
	SOC SEC NO								
DEPENDENT 1						<input type="radio"/> Child <input type="radio"/> Stepchild <input type="radio"/> Other	PCP		
	SOC SEC NO								
DEPENDENT 2						<input type="radio"/> Child <input type="radio"/> Stepchild <input type="radio"/> Other	PCP		
	SOC SEC NO								
DEPENDENT 3						<input type="radio"/> Child <input type="radio"/> Stepchild <input type="radio"/> Other	PCP		
	SOC SEC NO								
DEPENDENT 4						<input type="radio"/> Child <input type="radio"/> Stepchild <input type="radio"/> Other	PCP		
	SOC SEC NO								

Employee Signature

Date