

UNIVERSITY OF ARKANSAS  
ENROLLMENT APPLICATION



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(PLEASE PRINT FIRMLY – USE BALL POINT PEN)



UNIVERSITY OF ARKANSAS SYSTEM

NEW EMPLOYMENT/CHANGES IN ENROLLMENT

1. TYPE OF REQUEST (CHECK ALL APPROPRIATE BOXES)

NEW ENROLLMENT: ☐ EMPLOYEE ☐ EMPLOYEE & SPOUSE ☐ EMPLOYEE & CHILD(REN) ☐ EMPLOYEE, SPOUSE & CHILD(REN)  
PLAN SELECTED: ☐ CLASSIC ☐ POINT OF SERVICE ☐ ALTERNATE POS (OUT OF AREA RESIDENT)  
CHANGE: ☐ ADD SPOUSE/DEPENDENT ☐ CHANGE NAME/ADDRESS ☐ TERMINATE EMPLOYEE/SPOUSE/DEPENDENT

EMPLOYEE INFORMATION

2. NAME-LAST	FIRST	INITIAL	3. SOCIAL SECURITY NO.	4. DATE OF EMPLOYMENT	
5. MAILING ADDRESS	CITY		STATE	ZIP CODE	COUNTY
6. HOME PHONE NO. ( )	WORK PHONE NO. ( )	7. MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	<input type="checkbox"/> I WOULD LIKE TO PAY ON A PRE-TAX BASIS UNDER SECTION 125		

SPOUSE/DEPENDENT 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. RELATION- SHIP	12. LIST THE NAME & NUMBER OF THE PRIMARY CARE PHYSICIAN FROM THE DIRECTORY FOR EACH MEMBER	PHYS NO	CURRENT PATIENT (Y/N)
SELF						PCP		
SPOUSE						PCP		
DEPENDENT 1					<input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other	PCP		
DEPENDENT 2					<input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other	PCP		
DEPENDENT 3					<input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other	PCP		

12A. I do not wish to choose a Primary Care Physician. I understand by not choosing a Primary Care Physician that I, and any enrolled dependents, will have either reduced benefits (Point of Service) or no benefits (Classic).

Employee Signature \_\_\_\_\_

13. "IF DEPENDENT CHILDEN ARE 19 YEARS OF AGE OR OLDER, DO THEY ATTEND SCHOOL ON A FULL TIME BASIS?" ☐ YES ☐ NO

SCHOOL: \_\_\_\_\_ DEPENDENT NAME: \_\_\_\_\_ GRAD. DATE: \_\_\_\_\_  
SCHOOL: \_\_\_\_\_ DEPENDENT NAME: \_\_\_\_\_ GRAD. DATE: \_\_\_\_\_

14. IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO IF YES, PLEASE INDICATE

ADDRESS \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_

TELEPHONE \_\_\_\_\_

15. 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: \_\_\_\_\_

16. 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

17. I apply for enrollment in the University of Arkansas group medical program for the persons listed above and agree that my family members and I shall be covered according to the terms of the plan. 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 QualChoice and the Human Resource office, promptly in writing, concerning any changes in the above information.

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

FOR EMPLOYER/OFFICE USE

CAMPUS: ☐ ASMSA ☐ CES ☐ UAF ☐ Criminal Justice ☐ UA Foundation ☐ UA Walton Center

EFFECTIVE DATE \_\_\_\_\_

☐ UACCB ☐ UALR ☐ UAM ☐ UAMS ☐ UAPB ☐ WRI ☐ PCCUA

DATE OF CHANGE \_\_\_\_\_

☐ Other \_\_\_\_\_ ☐ EIN-780003452-NEW HIRE NOTICE

REASON FOR CHANGE \_\_\_\_\_ DOCUMENTATION ☐ YES ☐ NO