

ENROLLMENT APPLICATION

SPECIAL ENROLLMENT to add adult children 10-1-2010
Send to Human Resources by Sept 30, 2010



10825 Financial Centre Parkway, Suite 400
 Little Rock, AR 72211-3570
 501-228-7111 • Fax 501-228-0135
 (PLEASE PRINT FIRMLY – USE BALL POINT PEN)



NEW EMPLOYMENT/CHANGES IN ENROLLMENT

1. TYPE OF REQUEST

☒ **Add Adult Child who will be at least age 19 but not yet age 26 as of October 1, 2010**

Note: Your current taxation election – to pay the premium on either a before- tax or after- tax basis – will remain in effect. However, if your premium cost is changing because you are adding the "children" coverage tier for the first time, you can elect to change taxation of the premium. Contact Human Resources at 870-575-8400 if this is the case and we will provide you with the required form.

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		(intentionally left blank)		
()		()		<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED				

ADULT CHILD DATA

If more than three adult children are being added, use separate form. Birthdates must fall between 10-2-1985 to 10-1-1991.

8. LAST NAME	FIRST NAME	INITIAL	9. SEX (M/F)	10. BIRTHDATE MO DA YR	11. RELATIONSHIP	12. LIST THE NAME & NUMBER OF THE PRIMARY CARE PHYSICIAN FROM THE DIRECTORY FOR EACH MEMBER	PHYS NO	CURRENT PATIENT (Y/N)
DEP 1	SOC. SEC. NO.				<input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other	PCP		
DEP 2	SOC. SEC. NO.				<input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other	PCP		
DEP 3	SOC. SEC. NO.				<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. 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 _____

Send original to Human Resources by 9-30-2010. If faxing, send to (870) 575-4658. Keep fax confirmation as your proof.

FOR EMPLOYER/OFFICE USE

EFFECTIVE DATE: 10-1-2010

GROUP: _____

CAMPUS: UAPB