

UNIVERSITY OF ARKANSAS  
ENROLLMENT APPLICATION



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(PLEASE PRINT FIRMLY – USE BALL POINT PEN)

**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. FIRST_NAME		INITIAL	LAST_NAME		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		8. <input type="checkbox"/> I WOULD LIKE TO PAY ON A PRE-TAX BASIS UNDER SECTION 125		
9. EMAIL ADDRESS:								

**SPOUSE/DEPENDENT DATA (COMPLETE THIS SECTION FOR YOURSELF AND DEPENDENTS, IF MORE THAN THREE DEPENDENTS, USE SEPARATE FORM)**

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

14A. 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

15. IS YOUR SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE INDICATE ADDRESS		TELEPHONE	
NAME OF EMPLOYER			
16. DO YOU OR ANY OF YOUR DEPENDENTS HAVE OTHER GROUP MEDICAL COVERAGE: <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, IS COVERAGE <input type="checkbox"/> SINGLE OR <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO		PART A-HOSPITAL	PART B-MEDICAL
YES, NAME(S)		HEALTH INS. NO.	EFFECTIVE DATE

**SIGNATURE**

18. 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.  
Your adult children are eligible to be covered under your health plan up to age 26. 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 QualChoice and the Human Resource office promptly, in writing, concerning any changes in the above information.

Employee Signature

Date

FOR EMPLOYER/OFFICE USE		CAMPUS: <input type="checkbox"/> ASMSA <input type="checkbox"/> CES <input type="checkbox"/> UAF/Sub-Group #:	
EFFECTIVE DATE		<input type="checkbox"/> UACCB <input type="checkbox"/> UALR <input type="checkbox"/> UAM <input type="checkbox"/> UAMS <input type="checkbox"/> UAPB <input type="checkbox"/> WRI <input type="checkbox"/> PCCUA	
DATE OF CHANGE		<input type="checkbox"/> Other	<input type="checkbox"/> EIN-760003452-NEW HIRE NOTICE
REASON FOR CHANGE		DOCUMENTATION <input type="checkbox"/> YES <input type="checkbox"/> NO	