UNIVERSITY OF ARKANSAS SYSTEM

Health Insurance Enrollment Application

Benefits administered by:
UMR – 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 ❑Premier Plan ❑Health Savings Plan (For the Health Savings Plan, a separate HSA enrollment form is required)
(If no box checked, default is Classic)

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

❑ **REMOVE FAMILY MEMBER(S):** ❑Drop Spouse ❑Drop Child(ren)

❑ **TERMINATE ALL COVERAGE** ❑ **CHANGE NAME/ADDRESS**

EMPLOYEE INFORMATION

1. NAME-LAST	FIRST	INITIAL	2. SOCIAL SECURITY NUMBER	3. DATE OF EMPLOYMENT

4. MAILING ADDRESS	CITY	STATE	ZIP CODE	COUNTY

5. HOME PHONE NO. ( )	WORK PHONE NO. ( )	6. MARITAL STATUS ❑ SINGLE ❑ MARRIED	7. EMAIL ADDRESS

MEMBER DATA (COMPLETE THIS SECTION FOR YOURSELF AND DEPENDENTS YOU WANT TO ADD OR DROP. IF MORE THAN THREE DEPENDENTS, ADD SECOND FORM

	8. LAST NAME FIRST NAME INITIAL	9. SOC. SEC. NO. OR ALTERNATIVE NUMBER IS REQUIRED.	10. GENDER (circle one)	11. BIRTHDATE (month/day/year)	12. RELATIONSHIP
SELF		___ - ___ - ___	M or F	___ / ___ / ___	Self
SPOUSE		___ - ___ - ___	M or F	___ / ___ / ___	Spouse
DEP 1		___ - ___ - ___	M or F	___ / ___ / ___	☐ Child ☐ Step Child ☐ Other ___
DEP 2		___ - ___ - ___	M or F	___ / ___ / ___	☐ Child ☐ Step Child ☐ Other ___
DEP 3		___ - ___ - ___	M or F	___ / ___ / ___	☐ Child ☐ Step Child ☐ Other ___

12. IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO IF YES, PLEASE INDICATE EMPLOYER ADDRESS_____

NAME OF EMPLOYER_____ TELEPHONE_____

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:_____

14. ARE YOU OR ANY OF YOUR DEPENDENTS ELIGIBLE FOR MEDICARE? ☐ YES ☐ NO

YES, NAME(S)	HEALTH INS. NO.	PART A-HOSPTIAL EFFECTIVE DATE	PART B-MEDICAL EFFECTIVE DATE

SIGNATURE

15. 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 CAMPUS: UAMS

EFFECTIVE DATE _____ DATE OF CHANGE _____

REASON FOR CHANGE _____ DOCUMENTATION ☐ YES ☐ NO