UofA
UNIVERSITY OF ARKANSAS SYSTEM

Dental Insurance

Enrollment Application

Entire form must be completed.

Coverage subject to approval.

Arkansas Blue Cross and Blue Shield
PO Box 1460
Little Rock, AR 72203
Fax: 501-378-6925
Phone: 844-662-2281
uasenrollment@arkbluecross.com

New Enrollment: Employee Employee & Spouse Employee & Child(ren) Employee, Spouse & Child(ren)

Change: **Add** (check one or both) Spouse Child
Terminate (check all that apply) Employee Spouse Child

I would like to pay on a **pre-tax** basis. I understand that any change I need to make to my dental benefits can only take place within 31 days of a qualify change of status event, in accordance with Section 125 regulations

I would like to pay on a **post-tax** basis.

If neither box is checked, the current election will remain (or post-tax if new enrollment).

Part A: Employee / Subscriber Information

First name ___________________ **Initial** ______ **Last Name** ___________________ **Date of birth** ___ / ___ / _____ (Mo Day Year)

Street Address ________________________________ **APT#** _______ **Daytime Phone Number** ___________________

City ____________________________ **State** _________________ **Zip** __________ **Soc Sec Number** ____-___-_____

Marital Status: Single Married **Gender:** Male Female

Do you currently have other dental coverage? ____ (Y/N) *If yes, complete the following:*

Policyholder's name ________________________________ **Name of Employer** __________________________________

Policy # _________________________ **Name of Carrier** ____

Part B: Dependent Information

List the eligible family members you wish to enroll/add/delete.

	Add	Drop	First Name	MI	Last Name	Social Security Number	Date of Birth (Mo/Day/Year)	Gender (M/F)	Other Coverage? (Y/N)
Spouse						____-___-_____	(___/___/_____)		
Child						____-___-_____	(___/___/_____)		
Child						____-___-_____	(___/___/_____)		
Child						____-___-_____	(___/___/_____)		
Child						____-___-_____	(___/___/_____)		

Employee Signature ____ **Date** ___ / ___ / _____ (Mo Day Year)

Any person who knowingly presents a false or fraudulent claim for 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 and confinement in prison.

Part C: To be Completed by the Employer

Effective Date ___ / ___ / ______ (Mo Day Year) **Campus Name:** ____

Group # ____________________ **Applicant's Hire Date:** ___ / ___ / _____ (Mo Day Year)