

# Health Insurance Enrollment Application

(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
5. HOME PHONE NO. ( )	WORK PHONE NO. ( )	6. MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> 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
S E L F				___ - ___ - _____	M or F	___ / ___ / _____	Self
S P O U S E				___ - ___ - _____	M or F	___ / ___ / _____	Spouse
D E P 1				___ - ___ - _____	M or F	___ / ___ / _____	<input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other _____
D E P 2				___ - ___ - _____	M or F	___ / ___ / _____	<input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other _____
D E P 3				___ - ___ - _____	M or F	___ / ___ / _____	<input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other _____

12. IS YOUR SPOUSE EMPLOYED?  YES  NO IF YES, PLEASE INDICATE EMPLOYER ADDRESS \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
 NAME OF EMPLOYER \_\_\_\_\_

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-HOSPITAL 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:**  ASMSA  CES  UAF  Criminal Justice  UA Foundation  UA Walton Center  
 EFFECTIVE DATE \_\_\_\_\_  UACCB  UALR  UAM  UAMS  UAPB  WRI  PCCUA  UA FS  UAPulaski Tech  
 DATE OF CHANGE \_\_\_\_\_  Other \_\_\_\_\_  EIN-760003452-NEW HIRE NOTICE  
 REASON FOR CHANGE \_\_\_\_\_ DOCUMENTATION  YES  NO

# Dependent Verification for Insurance Coverage

**\*Documentation must be provided if you wish to add a spouse or dependent child to your health, dental or vision coverage.**

Coverage can be added within one month (31 days max) of: 1) initial eligibility as a new hire, 2) a change in status to benefits-eligible, 3) a qualifying life event; or 4) during an announced open enrollment period. Enrollment is effective within the next available coverage start date – generally the first of the following month – and is not retroactive (exception for newborns).

All supporting documentation as described below must be submitted at the time of enrollment. Benefit enrollment forms to enroll dependents will not be accepted if documentation is not provided. Therefore you may be required to re-complete forms for “employee only” coverage initially, with the option to revise your enrollment within 31 days.

This certifies that all dependents covered under my health, dental or vision insurance are my legal dependents as defined below. I understand that insurance fraud is generally defined as the “intentional misrepresentation of material facts and circumstances to an insurance company to obtain payment that would not otherwise be made” and disciplinary action will be taken, up to and including termination of employment, should this occur. In addition, I understand I will be held liable for any claims or fees incurred for the individual that is not a dependent.

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**Signature of Employee**

**Soc. Sec. Number or ID #**

**Date**

## **Documentation Provided Includes:**

Send fully legible photocopies only, not originals. Commemorative certificates and un-recorded documents are NOT acceptable.

### Proof for Legal Spouse

- Marriage License that is government-issued and signed by the country clerk, state registrar or other assigned government official. Must carry the seal of that office documenting the license has been recorded.

### Proof for Dependent Child under age 26

- Biological Child: government-issued Birth Certificate identifying you as the parent
- Newborn Child less than 31 days old: hospital issued Birth Certificate may be accepted if the document includes each of the following: newborn’s name, parent’s name, date of birth, and signature of the attending physician and/or hospital administration.
- Step-Child: government-issued Birth Certificate identifying your spouse as a parent AND a government-issued Marriage License showing you are married to the parent
- Adopted Child: court document showing adoption placement, petition for adoption or final adoption certificate; date of birth must be included
- Legal Ward/Guardian Child/Foster Child under age 18: court or agency documentation AND a government-issued Birth Certificate
- Medical Support Court Order: court documentation ordering you to provide insurance for your biological child
- Adult Disabled Child: government-issued Birth Certificate identifying you as the parent AND medical certification of disability prior to age 26. If the adult disabled child is your step-child, a government-issued Marriage License showing you are married to the parent is also required.