

UAMS Medical Coverage Change of Election Form

EMPLOYEE NAME	SOCIAL SECURITY NO.

I elect to change my medical care coverage option.
Effective January 1, 2010, I wish my coverage to be:

- CLASSIC MANAGED CARE PLAN** *(complete Primary Care Designation section below)*
- POINT-OF-SERVICE PLAN** *(complete Primary Care Designation section below)*
- POINT-OF-SERVICE ALTERNATE PLAN** *(out-of-state employees/retirees only)*

PRIMARY CARE PHYSICIAN DESIGNATION

	LAST NAME	FIRST NAME	INITIAL	SEX (M/F)	BIRTH DATE Mo/Day/Yr	RELATIONSHIP	LIST NAME & NUMBER OF PRIMARY CARE PHYSICIAN FROM THE DIRECTORY FOR EACH MEMBER	PHYSICIAN NO.	CURRENT PATIENT (Y/N)
S E L F							PCP		
	SOC SEC NO								
S P O U S E							PCP		
	SOC SEC NO								
D E P 1						<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	PCP		
	SOC SEC NO								
D E P 2						<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	PCP		
	SOC SEC NO								
D E P 3						<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	PCP		
	SOC SEC NO								
D E P 4						<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	PCP		
	SOC SEC NO								

Signature: _____

Date: _____

INSTRUCTIONS: *Make a photocopy for your records. Deliver original to Human Resources (1st floor Barton Research or G/800 Central Hospital across from old ER) or fax to (501) 603-1318 by Friday, December 18, 2009. Keep a copy for your records, including your fax confirmation.*