

**UAMS
ENROLLMENT APPLICATION**

OPEN ENROLLMENT for January 1, 2010
Send to UAMS Human Resources by December 18, 2009
Fax to (501) 603-1318 (keep your fax confirmation as proof)



10825 Financial Centre Parkway, Suite 400
Little Rock, AR 72211-3570
501-228-7111 • Fax 501-228-0135



(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
 (Note to biweekly: if you pretax your premium deduction and are dropping coverage, your last day to be covered is Dec 26, 2009.)

EMPLOYEE INFORMATION

2. NAME-LAST		FIRST	INITIAL	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		<input type="checkbox"/> I WOULD LIKE TO PAY ON A PRE-TAX BASIS UNDER SECTION 125	

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

8. LAST NAME	FIRST NAME	INITIAL	9. SEX (M/F)	10. BIRTHDATE MO DA YR	11. RELATIONSHIP	12. LIST THE NAME & NUMBER OF THE PRIMARY CARE PHYSICIAN FROM THE DIRECTORY FOR EACH MEMBER	PHYS NO	CURRENT PATIENT (Y/N)
SELF						PCP		
SOC. SEC. NO.								
SPOUSE						PCP		
SOC. SEC. NO.								
DEPENDENT 1					<input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other	PCP		
SOC. SEC. NO.								
DEPENDENT 2					<input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other	PCP		
SOC. SEC. NO.								
DEPENDENT 3					<input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other	PCP		
SOC. SEC. NO.								

12A. 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 _____

13. "IF DEPENDENT CHILDREN ARE 19 YEARS OF AGE OR OLDER, DO THEY ATTEND SCHOOL ON A FULL TIME BASIS?" YES NO
 SCHOOL: _____ DEPENDENT NAME: _____ GRAD. DATE: _____
 SCHOOL: _____ DEPENDENT NAME: _____ GRAD. DATE: _____

14. IS YOUR SPOUSE EMPLOYED? YES NO IF YES, PLEASE INDICATE ADDRESS _____
 NAME OF EMPLOYER _____ TELEPHONE _____

15. 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 DATE OF COVERAGE _____
 FAMILY MEMBERS COVERED AND RELATIONSHIP: _____

16. ARE YOU OR ANY OF YOUR DEPENDENTS ELIGIBLE FOR MEDICARE? YES NO HEALTH INS. NO. _____ PART A-HOSPITAL EFFECTIVE DATE _____ PART B-MEDICAL EFFECTIVE DATE _____

SIGNATURE

17. 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. 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:** ASMSA CES UAF Criminal Justice UA Foundation UA Walton Center
 EFFECTIVE DATE _____ UACCB UALR UAM UAMS UAPB WRI PCCUA
 DATE OF CHANGE _____ Other _____ EIN-760003452-NEW HIRE NOTICE
 REASON FOR CHANGE ___ Open Enrollment/end of year _____ DOCUMENTATION YES NO