

\*\*\*\*\* **SPECIAL OPEN ENROLLMENT FOR 2010. DEADLINE is 12-18-2009.** \*\*\*\*\*

Underwritten by: National Guardian Life Insurance Company, Madison, WI  
Administered by: Superior Vision Services, Inc.  
11101 White Rock Road, Suite 150, Rancho Cordova, CA 95670

## UAMS Vision Plan Enrollment Application

*Entire form must be completed. New coverage is effective 1-1-2010, subject to approval.  
Do not use this form if you are dropping Vision coverage altogether; use separate form*

### I. Check the Appropriate Boxes

**NEW ENROLLMENT:**  Employee  Employee & Spouse  Employee & Child(ren)  Employee, Spouse & Child(ren)  
**ADD FAMILY MEMBER** (check one or both boxes):  Spouse  Child(ren)  
**DROP FAMILY MEMBER:** (check one or both boxes):  Spouse  Child(ren)  
**PLAN OPTION:**  Basic Plan  Enhanced Plan (if box not checked, Basic Plan is the default)  
**PREMIUM DEDUCTION:**  Pre-tax  Post-tax (if box not checked, pre-tax is default)

*Important Notice: Mid-year drops are not permissible except in the case of employee termination or should a covered dependent become ineligible. Continuation of coverage under COBRA is available under those circumstances. Future new enrollments may be limited to Open Enrollment Periods.*

### II. Employee Information (please print clearly):

Your Name \_\_\_\_\_, \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle Initial)  
Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex (F or M) \_\_\_\_\_  
Home Street Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Do you or any of your dependents have other vision insurance?  Yes  No  
If yes, please give Policyholder's Name \_\_\_\_\_ and Insurance Company \_\_\_\_\_

### III. List All Eligible Family Members Below (if electing or terminating dependent coverage):

	First Name	Last Name	Birth Date	Full Time Student?	Add / Term
Spouse	_____	_____	____/____/____	not applicable	<input type="checkbox"/> <input type="checkbox"/>
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/>
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/>
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/>
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/>

**INSTRUCTIONS:** send to UAMS Human Resources by 4:30 pm, Friday, 12-18-2009. Fax to 501-603-1318 (keep your fax confirmation as proof) or send to campus mailbox 564-1.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_  
*Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to finds and confinement in prison.*

TO BE COMPLETED BY THE EMPLOYER:

Effective Date: \_\_\_\_\_ Group # 028770 Campus: UAMS