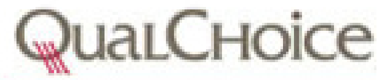
UNIVERSITY OF ARKANSAS
ENROLLMENT APPLICATION



EBEN-106
http://www.qcark.com 11-3-2004

NEW EMPLOYMENT/CHANGES IN ENROLLMENT

1. TYPE OR REQUEST (CHECK ALL APPROPRIATE BOXES)

NEW ENROLLMENT: ☐ EMPLOYEE ☐ EMPLOYEE & SPOUSE ☐ EMPLOYEE & CHILD(REN) ☐ EMPLOYEE, SPOUSE & CHILD(REN)

PLAN SELECTED: ☐ CLASSIC ☐ POINT OF SERVICE

CHANGE: ☐ ADD SPOUSE/DEPENDENT ☐ CHANGE NAME/ADDRESS ☐ TERMINATE EMPLOYEE/SPOUSE/DEPENDENT

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	
( )	( )	☐ SINGLE ☐ MARRIED	☐ I WOULD LIKE TO PAY ON A PRE-TAX BASIS UNDER SECTION 125.

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

	8. LAST NAME FIRST NAME INITIAL	9. SEX (M/F)	10. BIRTH DATE MO DAY YR	11. RELATION SHIP	12. LIST THE NAME & NUMBER OF THE PRIMARY CARE PHYSICIAN FROM THE DIRECTORY FOR EACH MEMBER	PHYS. NO.	CURRENT PATIENT (Y/N)
SELF	 SOC. SEC. NO.				PCP		
SPOUSE	 SOC. SEC. NO.				PCP		
DEP 1	 SOC. SEC. NO.			☐ Child ☐ Stepchild ☐ Other	PCP		
DEP 2	 SOC. SEC. NO.			☐ Child ☐ Stepchild ☐ Other	PCP		
DEP 3	 SOC. SEC. NO.			☐ Child ☐ Stepchild ☐ Other	PCP		

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 OF COVERAGE ________
FAMILY MEMBERS COVERED AND RELATIONSHIP ________

16. ARE YOU OR ANY OF YOUR DEPENDENTS ELIGIBLE FOR MEDICARE? ☐ YES ☐ NO

IF YES, NAME(S)	HEALTH INS. NO.	PART A – HOSPITAL EFFECTIVE DATE	PART B – MEDICAL EFFECTIVE DATE

SIGNATURES

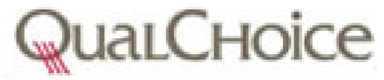
17. I apply for enrollment in the University of Arkansas group medical program for the persons listed above and agree that my family members and I shall be covered according to the terms of the plan.
I hereby authorize deductions from my earnings of any required contributions. To the best of my knowledge 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 of any coverage. I agree to notity QualChoice/QCA and the Human Resource Office promptly, in writing, concerning any changes in the above information.

____
Employee Signature **Date** Return 4 copies to C.E.S. Human Resources Office

FOR EMPLOYER/OFFICE USE CAMPUS: UAF-02 ☐ UALR-03 ☐ UAM-04 ☐ UAMS-05 ☐ CES-07 ☐ HIPAA/COBRA ☐ UA WALTON CENTER ☐ CRIMINAL JUSTICE ☐ UA FOUNDATION ☐ UA CREDIT UNION ☐ EIN 71-6003252 - - NEW HIRE NOTICE

EFFECTIVE DATE: ________
DATE OF CHANGE: ________
REASON FOR CHANGE ________ DOCUMENTATION ☐ YES ☐ NO

UNIVERSITY OF ARKANSAS
ENROLLMENT APPLICATION



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CHANGE: ☐ ADD SPOUSE/DEPENDENT ☐ CHANGE NAME/ADDRESS ☐ TERMINATE EMPLOYEE/SPOUSE/DEPENDENT

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5. MAILING ADDRESS	CITY	STATE	ZIP CODE	COUNTY

6. HOME PHONE NO.	WORK PHONE NO	7. MARITAL STATUS	
		☐ SINGLE ☐ MARRIED	☐ I WOULD LIKE TO PAY ON A PRE-TAX BASIS UNDER SECTION 125.

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

	8. LAST NAME / FIRST NAME / INITIAL	9. SEX (M/F)	10. BIRTH DATE MO DAY YR	11. RELATION SHIP	12. LIST THE NAME & NUMBER OF THE PRIMARY CARE PHYSICIAN FROM THE DIRECTORY FOR EACH MEMBER	PHYS. NO.	CURRENT PATIENT (Y/N)
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NAME OF INSURED ______ DATE OF BIRTH ______ EFFECTIVE DATE OF COVERAGE ______ TERMINATION OF COVERAGE ______
FAMILY MEMBERS COVERED AND RELATIONSHIP ______

16. ARE YOU OR ANY OF YOUR DEPENDENTS ELIGIBLE FOR MEDICARE? ☐ YES ☐ NO

IF YES, NAME(S)	HEALTH INS. NO.	PART A – HOSPITAL EFFECTIVE DATE	PART B – MEDICAL EFFECTIVE DATE

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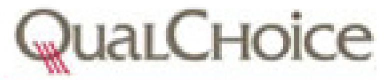
UNIVERSITY OF ARKANSAS
ENROLLMENT APPLICATION



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		☐ SINGLE ☐ MARRIED	

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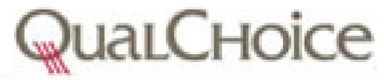

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