ARBenefits

RESET PRINT

ACTIVE STATE & PUBLIC SCHOOL CHANGE FORM

Part 1: Employee Information

First Name	MI	Last Name	Date of Birth	Gender ☐M ☐F	Social Security Number

Agency/School District Name (Required):	Group#	Home/Cell Phone Number	Work Phone Number

Home Address	City	State	Zip Code

Part 2: Action Requested

Type of Action

- ☐ Cancel Coverage
- ☐ Add/Drop Dependent

Effective Date: _____

Reason for this Action (You must check one of the following)

- ☐ Legal Guardianship
- ☐ Newborn/Adoption
- ☐ Marriage
- ☐ Divorce
- ☐ Death
- ☐ Gain/Loss of Employment
- ☐ Medicare/Medicaid/Tricare
- ☐ Other:

Select a Coverage Level

☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee & Family

Part 3: Add/Drop Dependents

Check the appropriate column to ADD eligible dependents not currently covered and/or DROP ineligible dependents. Proof of a dependent's eligibility must be submitted with this application for all dependents.

To complete the RELATIONSHIP column, use the number that describes your dependent(s).
Spouse - 1, Child - 2, Permanent Legal Guardianship - 3, Collateral Dependent - 4

Add	Drop	Name (First, MI, Last)	Date of Birth	Social Security Number	Male	Female	Relationship
☐	☐				☐	☐	
☐	☐				☐	☐	
☐	☐				☐	☐	
☐	☐				☐	☐	
☐	☐				☐	☐	
☐	☐				☐	☐	

Part 4: Subscriber Certification

I authorize deductions of the required contributions (if applicable). I understand that my elections can only be changed during the next open enrollment period or if I have a qualifying status change event as defined in the ARBenefits Summary Plan Description. I understand I must request such changes within 60 days of the qualifying event. On behalf of myself and anyone enrolled on or added to this form, I authorize any health care professional or entity to give the health plan/insurer or any of their designees, any and all records or information pertaining to medical history or services rendered to the health plan/insurer, for any administrative purpose, including evaluation of an application or a claim. I also authorize on behalf of health plan/insurer the use of a Social Security Number for the purpose of identification. A photocopy of this authorization will be as valid as the original. Please note that falsifying documents, misrepresenting dependent status or using other fraudulent actions to gain coverage may be criminal acts and can lead to permanent termination of coverage. I understand by signing the election form, it means I have read and agree with the attached instruction page and understand the options I chose on the election form.

Employee Signature	Date	Email Address:

SUBMISSION TO EBD IS FINAL

ARBenefits• Department of Finance and Administration • Employee Benefits Division
Post Office Box 15610 • Little Rock, AR 72231-5610 • Fax: 501.683.0983

Instruction Page

ALL PORTIONS OF THE ELECTION FORM MUST BE COMPLETED OR IT WILL BE SENT BACK FOR COMPLETION PRIOR TO PROCESSING.

Review your current benefits, the available plans and options. Then select the benefit options most suited to your personal needs.

Social Security Numbers are required for enrollment. If you do not provide a Social Security Number for yourself or your dependents, health insurance coverage cannot be provided. Exception: A newborn's Social Security number will be accepted after enrollment, but must be sent in once it is received.

You must drop all of your ineligible dependents. When your dependents no longer meet eligibility requirements, their coverage ends the last day of the month they became ineligible. You may be responsible for any cost for services received while your dependent was incorrectly listed as eligible.

Members may make changes to their plan if they experience a qualifying status change, but they may not elect a different plan.

If you experience a qualifying event that allows you to cancel your health insurance, you can only enroll again during the next annual open enrollment period or if you have a qualifying status change event. Qualifying status change events include those listed on this form, and may require that you provide proof that you have gained or lost group health care coverage.

You should receive plan information and ID cards in a timely manner from ARBenefits. If you do not, call ARBenefits at 1-877-815-1017 (When you hear the recording, Just Press One).

Your elections will remain in effect for the remainder of the calendar year unless you experience a qualifying status change event, as defined by the ARBenefits Summary Plan Description.

Your effective date of coverage will be the first of the month following date of application and following your qualifying event. Note: The qualifying event date is not the date of eligiblity.

Members who turn age 65 or become eligible for Medicare must send in a copy of their Medicare card to ARBenefits.

Proof of dependent eligibility is required. Examples of required documentation are: birth certificates, marriage licenses, court documents and a Certificate of Credible Coverage for loss of coverage.

Please mail or fax your completed and signed Health Insurance Election Form to:

ARBenefits
P.O. Box 15610
Little Rock, AR
72231-5610
Fax: 501-683-0983

For assistance, contact ARBenefits at 1-877-815-1017 Monday through Friday, from 8:00 a.m. to 4:30 p.m. CST.

Learn more about plans, costs and providers at www.arbenefits.org.