UNIVERSITY OF ARKANSAS SYSTEM

Dental Insurance

Enrollment Application

Entire form must be completed.

Coverage subject to approval.

Arkansas Blue Cross and Blue Shield
PO Box 1460
Little Rock, AR 72203
Fax: 501-378-6925
Phone: 844-662-2281
uasenrollment@arkbluecross.com

New Enrollment: ☐ Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee, Spouse & Child(ren)

Change: ☐ **Add** (check one or both) ☐ Spouse ☐ Child
☐ **Terminate** (check all that apply) ☐ Employee ☐ Spouse ☐ Child

☐ I would like to pay on a **pre-tax** basis. I understand that any change I need to make to my dental benefits can only take place within 31 days of a qualify change of status event, in accordance with Section 125 regulations

☐ I would like to pay on a **post-tax** basis.

If neither box is checked, the current election will remain (or post-tax if new enrollment).

Part A: Employee / Subscriber Information

First name _____ **Initial** _____ **Last Name** _____ **Date of birth** ___/___/_____ (Mo / Day / Year)

Street Address _____ **APT#** _____ **Daytime Phone Number** _____

City _____ **State** _____ **Zip** _____ **Soc Sec Number** ___-___-_____

Marital Status: ☐ Single ☐ Married **Gender:** ☐ Male ☐ Female

Do you currently have other dental coverage? _____ (Y/N) *If yes, complete the following:*

Policyholder's name _____ **Name of Employer** _____

Policy # _____ **Name of Carrier** _____

Part B: Dependent Information

List the eligible family members you wish to enroll/add/delete.

	Add	Drop	First Name	MI	Last Name	Social Security Number	Date of Birth (Mo/Day/Year)	Gender (M/F)	Other Coverage? (Y/N)
Spouse	☐	☐				___-___-_____	(___/___/_____)		
Child	☐	☐				___-___-_____	(___/___/_____)		
Child	☐	☐				___-___-_____	(___/___/_____)		
Child	☐	☐				___-___-_____	(___/___/_____)		
Child	☐	☐				___-___-_____	(___/___/_____)		

Employee Signature _____ **Date** ___/___/_____ (Mo / Day / Year)

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Part C: To be Completed by the Employer

Effective Date ___/___/_____ (Mo / Day / Year) **Campus Name:** _____

Group # _____ **Applicant's Hire Date:** ___/___/_____ (Mo / Day / Year)