UNIVERSITY OF ARKANSAS GROUP BENEFITS CHANGE FORM

Campus: ☐UAASMSA ☐UACCB ☐UACES ☐UAF ☐UALR ☐UAMS ☐UAM ☐UAPB ☐OTHER____

EMPLOYEE LAST NAME	FIRST NAME	MI	BIRTHDATE	SEX	SOC SEC NO

NAME CHANGE: FROM:______________________ EFFECTIVE DATE:__________

OPTIONAL LIFE

☐ADD ☐1X ☐2X ☐3X ☐4X ~CANCEL COVERAGE	☐EVIDENCE OF INSURABILITY COMPLETED	EFFECTIVE DATE:__________
☐INCREASE FROM______TO______ ☐DECREASE FROM______TO______	☐EVIDENCE OF INSURABILITY COMPLETED	EFFECTIVE DATE:__________

DEPENDENT LIFE

☐ADD AMOUNT________ ☐CANCEL COVERAGE	☐EVIDENCE OF INSURABILITY COMPLETED	EFFECTIVE DATE:__________
☐INCREASE FROM_______TO_______ ☐DECREASE FROM_______TO_______	☐EVIDENCE OF INSURABILITY COMPLETED ☐REASON:__________________	EFFECTIVE DATE:__________

OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT

☐ADD EMPLOYEE ON LY COVERAGE ☐ADD FAMILY COVERAGE ☐CANCEL COVERAGE	COVERAGE AMOUNT____________________ EFFECTIVE DATE ____________________ EFFECTIVE DATE ____________________
☐INCREASE FROM_______TO_______ ☐DECREASE FROM_______TO_______	☐ EMPLOYEE COVERAGE OF $________________ ☐ FAMILY COVERAGE OF ________________

OPTIONAL LONG TERM DISABILITY

☐ADD ☐CANCEL COVERAGE	☐SALARY ELIGIBILITY OF $20,000 ☐EVIDENCE OF INSURABILITY COMPLETED	EFFECTIVE DATE:__________

BENEFICIARY CHANGES

List below the individual(s) you designate to receive proceeds from your Basic Life Insurance, Optional Life Insurance (if elected), and Optional Accidental Death & Dismemberment Insurance (if elected). Unless otherwise indicated, payment will be made equally to all persons named. If no beneficiary is living at the time of distribution, payment will be made according to the policy terms. This supersedes any other beneficiary designation. The employee is the beneficiary of all dependent death benefits. (If space is needed for additional beneficiary designations, please us a separate page and attach.

P=Primary S=Secondary / B=Basic O=Optional A=Accidental Death & Dismemberment

NAME (Last, First, MI)	SEX	RELATIONSHIP	P/S OR %	BENEFIT CODES
				☐ B ☐ O ☐ AD&D
				☐ B ☐ O ☐ AD&D
				☐ B ☐ O ☐ AD&D

EMPLOYEE SIGNATURE:______________________________ Date:__________

BENEFITS REPRESENTATIVE:______________________________ Date:__________

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