

Fax form to ARSEBA
(501) 663-1445

Arkansas State Employees Benefit Advisors
1301 West 7th Street, Little Rock, AR 72201
Questions? Call (501) 224-5234 or (888) 224-5233



**ARKANSAS STATE EMPLOYEES
BENEFIT ADVISORS**

AGENCY NAME: <u>Auditor of State</u>	For internal use only: Non-AASIS Delta Dental Group Number: <u>3571-0AR10000</u> <u>3571-1AR10000</u> Effective Date: (MM) (DD) (YY)
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LAST NAME: _____	FIRST: _____	MI: _____
SSN: _____	PERSONNEL NUMBER: (employee ID) _____	
STREET ADDRESS: _____		
CITY: _____	STATE: _____	ZIP: _____
PHONE: () _____	EMAIL: _____	
DATE OF HIRE: ____ (MM) ____ (DD) ____ (YY)	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
DATE OF BIRTH: ____ (MM) ____ (DD) ____ (YY)	MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	

1. COVERAGE CHANGES *Please check the box(es) next to the reason for your change

Type of coverage selected & plan option (choose one)	Reason(s) for Status Change:		
<table style="width:100%; border: none;"> <tr> <td style="width:50%; border-right: 1px solid black; padding: 5px;"> Base Dental <input type="checkbox"/> Employee \$20.60 <input type="checkbox"/> Employee/Spouse \$41.06 <input type="checkbox"/> Employee/Child(ren) \$40.12 <input type="checkbox"/> Employee/Family \$66.48 </td> <td style="width:50%; padding: 5px;"> Premium Dental <input type="checkbox"/> Employee \$30.72 <input type="checkbox"/> Employee/Spouse \$61.22 <input type="checkbox"/> Employee/Child(ren) \$59.78 <input type="checkbox"/> Employee/Family \$99.08 </td> </tr> </table>	Base Dental <input type="checkbox"/> Employee \$20.60 <input type="checkbox"/> Employee/Spouse \$41.06 <input type="checkbox"/> Employee/Child(ren) \$40.12 <input type="checkbox"/> Employee/Family \$66.48	Premium Dental <input type="checkbox"/> Employee \$30.72 <input type="checkbox"/> Employee/Spouse \$61.22 <input type="checkbox"/> Employee/Child(ren) \$59.78 <input type="checkbox"/> Employee/Family \$99.08	<input type="checkbox"/> Open enrollment <input type="checkbox"/> Marriage* <input type="checkbox"/> Divorce* <input type="checkbox"/> Birth or adoption of child* <input type="checkbox"/> Loss of spouse's coverage* <input type="checkbox"/> No longer dependent child* <input type="checkbox"/> Death of dependent* <input type="checkbox"/> Name Change <input type="checkbox"/> Other
Base Dental <input type="checkbox"/> Employee \$20.60 <input type="checkbox"/> Employee/Spouse \$41.06 <input type="checkbox"/> Employee/Child(ren) \$40.12 <input type="checkbox"/> Employee/Family \$66.48	Premium Dental <input type="checkbox"/> Employee \$30.72 <input type="checkbox"/> Employee/Spouse \$61.22 <input type="checkbox"/> Employee/Child(ren) \$59.78 <input type="checkbox"/> Employee/Family \$99.08		
Monthly Rates effective January 1, 2020 – December 31, 2020	<input type="checkbox"/> New Hire <input type="checkbox"/> Agency Change <input type="checkbox"/> Term Coverage <input type="checkbox"/> Status Change <input type="checkbox"/> Address Change *Date of event above: _____		

2. LIST ALL MEMBERS TO BE ENROLLED OR AFFECTED BY CHANGE

Add	Remove	Last Name	First Name	MI	Spouse or Dependent	Gender M/F	Birthdate (MM/DD/YY)
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						

3. AUTHORIZATION

I authorize dentists, dental office personnel, and other health care professionals and entities to disclose to Delta Dental of Arkansas, its agents and employees (including, without limitation, its claims and customer service personnel) all information necessary to determine (1) eligibility for coverage and (2) covered benefits. This authorization is made for each individual to be enrolled or affected by this change. The authorization is valid for 30 months from the date this form is signed for the purpose of collecting information in connection with enrollment, coverage reinstatement, or requests to change benefits. The authorization is valid for the term of coverage for the purpose of collecting information in connection with claims for benefits. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.

4 CERTIFICATION

I certify that the information supplied by me on this form is accurate to the best of my knowledge. 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.

I authorize payroll deductions.

Signature: _____ Date: _____