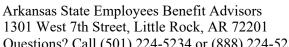


Fax form to ARSEBA (501) 663-1445





			Questions? Call					ADVISORS	
		For internal use only:							
ACENCY NAME: Auditor of State					a Dental Group Num		-		
AGENCY NAME: Auditor of State				ctive Date:	(MM)	(DD)	(YY)		
			ST:		- TD)	MI:			
SSN:			PERSON	INEL NUM	BER: (employee	E ID)			
	EET ADD	RESS:							
CITY:			STATE:		ZIP:				
PHO	NE: _()		EMAIL:					
DAT	E OF HIR	.E:(MM)_	(DD)(YY)	GENDE	R: MALE	☐ FEMAI	LE		
DAT	E OF BIR	TH:(MM)	(DD)(YY)	MARITA	AL STATUS: [SINGLE	☐ MAI	RRIED	
1. C	COVERA	GE CHANGES		*Please che	ck the box(es)	next to the re	eason for	your change	
Type of coverage selected & plan option (choose one)				Open enrollment Reason(s)			or Status C	Change:	
<u>Base Dental</u> <u>Premium Dental</u>			Premium Dental	☐ New Hire		☐ Marriage*			
Employee \$20.60			Employee \$30.72				☐ Divorce*☐ Birth or adoption of child*		
Employee/Spouse \$41.06			Employee/Spouse \$61.22	Agend	Agency Change ☐ Loss		of spouse's coverage* nger dependent child*		
Employee/Child(ren) \$40.12			Employee/Child(ren) \$59.78	☐ Term	☐ Term Coverage ☐ Death o				
Employee/Family \$66.48			Employee/Family \$99.08	Status	Status Change		nange		
Monthly Rates effective January 1, 2020 – December 31, 2020				*Date of event above:					
					ess Change	*Date of ever	nt above:		
2. L	IST ALL	MEMBERS TO	O BE ENROLLED OR AFFE	CTED BY	CHANGE				
Add	Remove	Last Name	First Name	MI	Spouse of Depender			irthdate M/DD/YY)	
I authori	ize dentists, d limitation, it	ts claims and customer	and other health care professionals and entit servic e personnel) all information necess	ary to determ i	ne (1) eligibi lity f	or cover age an	d (2) covere	ed benefits. This	
purpose coverage a copy o	of collecting e for the purp of the authoriz	s informat ion in connectors of collecting information form.	be enrolled or aff ected by this change. The ction with enrollment, coverage reinstatementation in connection with claims for benefits	ent, or requests	t o change benefits	 The a uthorize 	zation is val	id for the term of	
I certif		ormation supplied by m ss or benefit or knowing	e on this form is accurate to the best of my k ly presents false information in an application						
ПТаг		11 1 1 2							
	uthorize pay	roll deductions.							

Note: For new hires, the effective date will be first of the month following the signature date provided on this form.