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State of Arkansas

ARSEBA
ARKANSAS STATE EMPLOYEES
BENEFIT ADVISORS

VisionCare Enrollment/Change Form

Arkansas State Employees Benefit Advisors
1301 West 7th Street
Little Rock, Arkansas 72201
(501) 224-5234, Toll Free (888) 224-5233

Current Agency Name: Auditor of State	Employee Number:	Group Number:
If this is an agency change, previous Agency Name: _____		

Social Security No.	Last Name	First	MI	**Date of Birth** / /
Home Address				**Date of Hire** / /
City		State	Zip Code	Gender M ☐ F ☐
Home Phone ( )	Business Phone ( )			Marital Status Single ☐ Married ☐

List all members to be enrolled or affected by change

Add	Remove	Last Name	First Name	MI	Spouse or Dependent	Gender M/F	Date of Birth (MM/DD/YYYY)
☐	☐						/ /
☐	☐						/ /
☐	☐						/ /
☐	☐						/ /
☐	☐						/ /
☐	☐						/ /
☐	☐						/ /

Coverage Changes

*Please check the box(es) next to the reason for your change

Type of Coverage (Select One)		Reason(s) for Status Change:
	☐ Open enrollment	☐ Marriage*
☐ Employee Only **$8.24** (Monthly)	☐ New Hire	☐ Divorce*
		☐ Birth or Adoption of Child*
☐ Employee Family **$21.42** (Monthly)	☐ Agency Change	☐ Loss of spouse's coverage*
		☐ Dependent no long eligible*
Plan Code: VISION	☐ Status Change	☐ Death of Dependent*
		☐ Name Change
Agent Number: 1738312	☐ Term Coverage	☐ Address Change
		☐ Other _____
EFFECTIVE DATE: _____		* Date of Event Above: _____

I wish to enroll/change in the plan indicated above as offered through my employer. I understand that this is a minimum one (1) year contract. I hereby authorize my employer to deduct all applicable contribution amounts from my salary or other compensation for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan.

I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

FAX COMPLETED FORM TO ARSEBA: (501) 663-1445

Signature: _____ Date: _____