AR BENEFITS

State & Public-School Employee Election Form

This form is to be used for Open Enrollment and New Enrollees ONLY. Please use the Change Form for other Qualifying Events.

Employee Information

First Name	MI	Last Name	Date of Birth	Gender	Social Security Number
				☐M ☐F	

Agency or District	Group Number	Home/Cell Number	Work Number
Auditor of State	059		

Mailing Address	City	State	Zip Code

Physical Address

☐ **ONLY** check this box if you wish to have your premiums withheld on a **post-tax** basis

Coverage

Reason for Enrollment

- ☐ Open Enrollment
- ☐ New Hire Period
- ☐ Loss of Group Coverage
- ☐ Loss of Medicaid
- ☐ Newborn

Type of Action

- ☐ Enroll in the Plan
- ☐ Add/Drop Dependant(s)
- ☐ Decline Coverage

Pick a Benefit Option

☐ Premium ☐ Classic ☐ Basic

Pick Coverage Level

☐ Employee Only ☐ Employee & Child(ren)
☐ Employee & Spouse ☐ Employee & Family

Add/Drop Dependents

Please check the correct column to ADD a dependent to the plan or DROP a dependent currently covered. Proof of a dependent's eligibility must be submitted with this application for all dependents. To complete the RELATIONSHIP column, use the number that describes the dependent(s). Spouse - 1, Child - 2, Permanent Legal Guardianship - 3

ADD	DROP	NAME (FIRST, MI, LAST)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MALE	FEMALE	RELATIONSHIP
☐	☐				☐	☐	
☐	☐				☐	☐	
☐	☐				☐	☐	
☐	☐				☐	☐	

Subscriber Certification

I authorize deductions of the required contributions (if applicable). I understand that my elections can only be changed during the next open enrollment period or if I have a qualifying event as defined in the ARBenefits Summary Plan Description. I understand I must request such changes within 60 days of the qualifying event. On behalf of myself and anyone enrolled on or added to this form, I authorize any health care professional or entity to give the health plan/insurer or any of their designees, any and all records or information pertaining to medical history or services rendered to the heath plan/insurer, for any administrative purpose, including evaluation of an application or claim. I also authorize on behalf of health plan/insurer the use of a Social Security Number for the purpose of identification. A photocopy of this authorization will be as valid as the original. Please note that falsifying documents, misrepresenting dependent status or using other fraudulent actions to gain coverage may be criminal acts and can lead to permanent termination of coverage. I understand by signing the election form, it means I have read and agree with the attached instruction page and understand the options I chose on the election form.

Employee Signature	Date	Email Address

FOR PSE HIR USE ONLY: Board Approval Date:_____ Contract Start Date:_____

SUBMISSION TO EMPLOYEE BENEFITS DIVISION IS FINAL

Department of Transformation and Shared Services • Employee Benefits Division
P.O. Box 15610 • Little Rock, AR 72231-5610 • Fax: 501-683-0983

Coverage is effective 1st of the month and termed at the end of the month following date of receipt and based on eligibility rules.

Instructions

ALL PORTIONS OF THE ELECTION FORM MUST BE COMPLETED OR IT WILL BE SENT BACK FOR COMPLETION PRIOR TO PROCESSING.

Social Security Numbers are required for enrollment. Exception: A newborn's Social Security Number will be accepted after enrollment but must be sent in once it is received.

You must drop all of your ineligible dependents. When your dependents no longer meet eligibility requirements, their coverage ends the last day of the month they became ineligible. You may be responsible for any cost for services received by any dependent(s) while your dependent(s) was incorrectly listed as eligible.

If you experience a qualifying event that allows you to cancel your health insurance, you can only enroll again during the next annual open enrollment period or if you have a qualifying status change event. Qualifying status change events include marriage, birth, and loss of group coverage.

You should receive ID cards in a timely manner from the Employee Benefits Division (EBD). If you do not, call EBD at 1-877-815-1017 (when you hear the recording, press 1).

Your effective date of coverage will be the first of the month following date of EBD receiving application and **ALL** corresponding documentation. Note: The qualifying date is NOT the date of eligibility.

Pre-tax premiums increase your take-home pay because your insurance premiums will be deducted from your salary before taxes are calculated. You will automatically be in a pre-tax status unless you select the post-tax option on this form and/or notify your payroll clerk.

Active members who turn age 65 or become eligible for Medicare must send in a copy of their Medicare card to EBD.

Supporting documentation is required for proof of dependent eligibility. For changes being made due to a qualifying event, documented proof a qualifying event has occurred is also required such as a Certificate of Credible Coverage (COCC). More information is available in the ARBenefits Summary Plan Description.

If adding a dependent as a Permanent Legal Guardian your account will be subject to an annual review.

If a Member is currently not enrolled on the plan and has a newborn, only **ONE** parent is permitted to enroll with the newborn.

Competed election forms can be submitted to EBD by fax, mail, or online through the ARBenefits Member Portal at www.myarbenefits.org.

For assistance, contact EBD at 1-877-815-1017 Monday - Friday, from 8:00AM - 4:30PM CST or email Ask.EBD@arkansas.gov. To learn more about plans, costs, and network providers visit www.transform.ar.gov/employee-benefits.

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