Humana.

**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: | | VS 8531 |

| 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: _____