UNIVERSITY OF CENTRAL ARKANSAS

Dental Benefit Enrollment/Change Form

HumanResources@uca.edu
501-450-3181
501-450-5088 fax

UCA Human Resources Only
Date Received _____
Reviewed By _____

Staff_____ **BANNER**
PDADEDN ____
Faculty____ PDABENE ____
PDABCOV ____
9/12 ___ Entered by ____

Employee Name (First, MI, Last)_____

Address_____ City_____ State_____ Zip_____

SS #_____ Hire Date_____ Marital Status_____

Daytime Phone #_____ Work Phone_____

DOB_____ Gender_____

Qualifying Event *(select only one)*

- ☐ New Hire
- ☐ Marriage
- ☐ Divorce
- ☐ Birth or Adoption of a Child
- ☐ Death of Spouse or Child
- ☐ Dependent Lost Eligibility Status
- ☐ Dependent Regains Eligibility Status
- ☐ Gain of Other Coverage
- ☐ Loss of Other Coverage
- ☐ Other (list the event below)
- ☐ PT to FT Employment
- ☐ FT to PT Employment
- ☐ Unpaid Leave of Absence
- ☐ OPEN ENROLLMENT

Date of qualified event-must be within 30 days of event

BCBS Dental Coverage

- ☐ Enroll
- ☐ Change
- ☐ Waive Coverage
- ☐ Base Plan
- ☐ Enhanced Plan

(List Dependents Below)

Type of Coverage after Changes (select only one):
- ☐ Employee Only
- ☐ Employee + Child(ren)
- ☐ Employee + Spouse
- ☐ Family
- ☐ Special Family

Effective Date: _____

Social Security #	Name (First, MI, Last)	Relationship	Sex (M/F)	Birthdate (m/d/yy)	Current	Add	Delete

Federal law requires certain restrictions on enrollment, changes, or cancellation of these benefits. Benefit Summaries and Summary Plan Descriptions are posted on UCA's Human Resources Webpage at www.uca.edu/hr. I understand that by enrolling in benefits I must remain in the selected plan until open enrollment or unless I have a qualifying event. Any person who knowingly presents a false or fraudulent claim payment of a loss or benefit or knowingly presents false information in an application for insurance may be subject to termination of employment.

I confirm that the information I have provided within this form is complete and accurate.

Signature _____ Date _____