UNIVERSITY OF ARKANSAS GROUP BENEFITS CHANGE FORM

EBEN-226
4-12-2005

Campus: ☐ UAF ☐ UALR ☐ UAM ☐ UAMS ☐ UAPB ☐ UA SYSTEM ☑ CES

Employee Last Name	First Name	M.I.	Birth Date	Sex	Employee I.D. Number

Name Change: From: _____ Effective Date: _____

Optional Life

☐ Add ☐ 1X ☐ 2X ☐ 3X ☐ 4X ☐ Cancel Coverage	☐ Evidence of Insurability Completed	Effective Date: _____
☐ Increase From _____ to _____ ☐ Decrease From _____ to _____	☐ Evidence of Insurability Completed	Effective Date: _____

Dependent Life

☐ Add Amount _____ ☐ Cancel Coverage	☐ Evidence of Insurability Completed	Effective Date: _____
☐ Increase From _____ to _____ ☐ Decrease From _____ to _____	☐ Evidence of Insurability Completed	Effective Date: _____

Optional Accidental Death and Dismemberment

☐ Add Employee only Coverage ☐ Add Family Coverage ☐ Cancel Coverage	Coverage Amount _____ Employee Coverage Amount _____	Effective Date: _____
☐ Increase From _____ to _____ ☐ Decrease From _____ to _____	☐ Employee Coverage ☐ Family Coverage	Effective Date: _____

Optional Long Term Disability

☐ Add ☐ Cancel Coverage	☐ Salary Eligibility of $20,000 ☐ Evidence of Insurability Completed	Effective Date: _____

Beneficiary Changes

List below the individual(s) you designate to receive proceeds from your Basic Life Insurance, Optional Life Insurance (if elected), and Optional Accidental Death & Dismemberment insurance (if elected). Unless otherwise indicated, payment will be made equally to all persons named. If no beneficiary is living at the time of distribution, payment will be made according to the policy terms. This supersedes any other beneficiary designation. The employee is the beneficiary of all dependent death benefits. (If space is needed for additional beneficiary designations, please use a separate page and attach.

P = Primary S = Secondary / B = Basic O = Optional A = Accidental Death & Dismemberment

Name (Last, First, M.I.)	Sex	Relationship	P/S or %	Benefit Codes
				☐ B ☐ O ☐ AD&D
				☐ B ☐ O ☐ AD&D
				☐ B ☐ O ☐ AD&D
				☐ B ☐ O ☐ AD&D

Employee Signature: _____ Date: _____

Benefits Representative: _____ Date: _____

Return 2 copies to CES Human Resources Office

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Employee Signature: _____ Date: _____

Benefits Representative: _____ Date: _____

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