



Phone: (501) 682-9656

Toll Free: (877) 815-1017

Fax: (501) 683-0983

<http://www.ARBenefits.org>

**Public School Employees
 Enrollment Form**



1. Employee Information: (please print)				<input type="checkbox"/> I decline coverage for myself	
Last Name		First Name		MI	Gender <input type="checkbox"/> Married <input type="checkbox"/> Single
Home Address		City		State	Zip Code
Social Security #:	Date of Birth:	Home #:		Work #:	
†Primary Care Physician:			PCP #	Current patient?	

†Primary Care Physician lines are applicable for HMO and POS enrollees only, not PPO.

2. Dependent Coverage Information:				<input type="checkbox"/> I decline coverage for my dependents		
SPOUSE	LAST NAME		FIRST NAME		MI	GENDER
	Social Security #:		Date of Birth:			
	†Primary Care Physician:			PCP #	Current patient?	
DEPENDENT 1*	LAST NAME		FIRST NAME		MI	GENDER
	Social Security #:		Date of Birth:		Full time student?*	
	†Primary Care Physician:			PCP #	Current patient?	
DEPENDENT 2*	LAST NAME		FIRST NAME		MI	GENDER
	Social Security #:		Date of Birth:		Full time student?*	
	†Primary Care Physician:			PCP #	Current patient?	
DEPENDENT 3*	LAST NAME		FIRST NAME		MI	GENDER
	Social Security #:		Date of Birth:		Full time student?*	
	†Primary Care Physician:			PCP #	Current patient?	

* Please submit guardianship, court-ordered insurance responsibility or adoption papers on dependents for which those documents apply.

**To be completed for dependents 19 and over only. Please submit proof of student status.

3. I Wish To Enroll In The Following Plan:			
HMO	POS	PPO	HD PPO
<input type="checkbox"/> Health Advantage <input type="checkbox"/> NovaSys Health <input type="checkbox"/> QualChoice/QCA	<input type="checkbox"/> Health Advantage <input type="checkbox"/> NovaSys Health <input type="checkbox"/> QualChoice/QCA	<input type="checkbox"/> Ark. Blue Cross & Blue Shield <input type="checkbox"/> NovaSys Health	<input type="checkbox"/> NovaSys Health
<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Employee & Children	<input type="checkbox"/> Family

4. Other Medical Insurance:

- 1) Will you or any of your family members be continuing any other health insurance? Yes No
 2) If Yes, what type of coverage? Medical Medicare, HIC # _____
 If Medicare: Part A Effective Date / / or Part B Eff Date / /
 If Medicare: Reason for Coverage: Over age 65 Disabled Kidney Disease

Please make sure EBD and your carrier has a copy of your Medicare card.

If you answered Yes to the question above, complete below: (Use additional paper if necessary)

Covered Person's Name	Coverage Type (single/family)	Effective Date	Policy Holder's Employer

Name/Address/Phone/Policy # of Health Ins Co.:

5. To Be Completed By School District:

School District #:	Name of School District:	
Employee #:	Hire Date:	Effective Date of Coverage:
If employee is transferring from another agency/district, please provide name:		

School Business Official Signature: _____

Print Name: _____

6. Please Read Before Signing:

I understand and agree that: (1) The information provided on this application is accurate and complete. (2) Any omissions or incorrect statements made by myself or anyone on this application may invalidate my and/or my dependents' coverage. (3) Coverage will become effective only on the date specified by the Insurer after the Insurer has approved the application and after the first full premium has been paid. (4) My signature authorizes Coordination of Benefits under this coverage with other insurance I have that is subject to coordination. (5) I hereby authorize deductions from my earnings of any required insurance contribution. (6) By signing this enrollment form, I hereby certify that all the information provided is true and correct.

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application, I authorize any health care professional or entity to give the health plan/insurer and the employer or any of their designees, any and all records or information pertaining to medical history or services rendered, to the health plan/insurer for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purpose, including evaluation of an application or a claim. I also authorize on behalf of the health plan/insurer, the use of a Social Security Number for purpose of identification. A photocopy of this authorization will be as valid as the original.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I understand that if I refuse to apply now and I apply for coverage at a later date, my request may be deferred until open enrollment.

Employee's Signature: _____ **Date:** _____