



Current Agency Name: <u>Auditor of State</u>				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 <input type="checkbox"/> F <input type="checkbox"/>
Home Phone ()		Business Phone ()		Marital Status Single <input type="checkbox"/> Married <input type="checkbox"/>	

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)
<input type="checkbox"/>	<input type="checkbox"/>						/ /
<input type="checkbox"/>	<input type="checkbox"/>						/ /
<input type="checkbox"/>	<input type="checkbox"/>						/ /
<input type="checkbox"/>	<input type="checkbox"/>						/ /
<input type="checkbox"/>	<input type="checkbox"/>						/ /
<input type="checkbox"/>	<input type="checkbox"/>						/ /
<input type="checkbox"/>	<input type="checkbox"/>						/ /

Coverage Changes

*Please check the box(es) next to the reason for your change

Type of Coverage (Select One)	<input type="checkbox"/> Open enrollment	Reason(s) for Status Change:
<input type="checkbox"/> Employee Only \$8.24 (Monthly)	<input type="checkbox"/> New Hire	<input type="checkbox"/> Marriage*
<input type="checkbox"/> Employee Family \$21.42 (Monthly)	<input type="checkbox"/> Agency Change	<input type="checkbox"/> Divorce*
Plan Code: VISION	<input type="checkbox"/> Status Change	<input type="checkbox"/> Birth or Adoption of Child*
Agent Number: 1738312	<input type="checkbox"/> Term Coverage	<input type="checkbox"/> Loss of spouse's coverage*
EFFECTIVE DATE: _____		<input type="checkbox"/> Dependent no long eligible*
		<input type="checkbox"/> Death of Dependent*
		<input type="checkbox"/> Name Change
		<input type="checkbox"/> Address Change
		<input type="checkbox"/> Other _____
		* 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: _____