University of Central Arkansas
201 Donaghey Avenue
Conway, AR 72035

GROUP ENROLLMENT FORM
FOR HOSPITAL GAP PLAN

Enroll **Address Change** **Decline**
Cancel **Name Change**
Change **Date of Change**_____

PROPOSED INSURED

LAST NAME | FIRST NAME | FULL MIDDLE NAME | SUFFIX

AGE | DATE OF BIRTH | Gender | SOC SEC NUMBER

STREET ADDRESS | CITY | STATE | ZIP CODE

( ) HOME PHONE NUMBER ( ) WORK PHONE NUMBER

DATE OF EMPLOYMENT | OCCUPATION | E-MAIL ADDRESS

SELECT PLAN DESIRED

☐ EMPLOYEE ONLY $0 ☐ EMPLOYEE & FAMILY $10.00/MONTH ☐ FACULTY & FAMILY $12.00/MO (10 MONTHS)

DEPENDENTS

Spouse/Name	Sex	Date of Birth	Enroll	Cancel
Child/Name	Sex	Date of Birth	Enroll	Cancel
Child/Name	Sex	Date of Birth	Enroll	Cancel
Child/Name	Sex	Date of Birth	Enroll	Cancel

If more space is needed, please continue on the backside of this application

AUTHORIZATION

I hereby enroll, add or change, as checked above, coverages of group insurance for which I am eligible. I authorize my employer to deduct my contributions, if any, from my pay. I have decided, after understanding and careful thought, not to take advantage of the other unchecked coverages for which I am eligible. I understand that proof of good health will be required for me and/or my dependents if I decide to apply for any available coverage 31 days after the date of eligibility. Such proof will be at my own expense. **ANY CHANGES REQUIRES WRITTEN NOTICE.** To the best of my knowledge and belief, the statements and answers shown in this application (first page and, if applicable, the second page) are true and complete. I understand and agree: a) that the Company may rely upon such answers as the basis of my contract; and b) that no coverage will take effect until a Policy or Certificate is issued. I understand that "pre-existing conditions" are generally not covered under the coverage(s) applied for. I should read my Certificate for a more detailed explanation of the pre-existing exclusion or limitation, if any. A new Pre-Existing Condition period must be satisfied with respect to any increase applied for and approved by the Company.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer; makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud.

SIGNATURE (Applicant) DATE

REVISED 10/21/2010