	2022	Effective Date:
CITY OF PINE BLUFF ARKANSAS	_____ New Applicant _____ Updating Information _____ Updating General _____ Transferring to a different plan _____ Terminate Coverage _____ Adding/Removing Dependent(s)	UnitedHealthcare

General Information

Name: Last	First	MI	Social Security Number:

Street Address City State Zip	Marital Status: _____Separate _____Single _____ Divorced _____Widowed _____ Married Date of Marriage: / /

Daytime Phone:	Evening Phone:	Is this a new address?	Hire Date: _____/_____/_____

(Please complete the information for any family members covered)

Name (Last, First M)	SS#	Relationship	Date of Birth	Sex	Full Time Student

Medical Coverage (Plans and Premiums are subject to change in January of each year)

HDHP Plan CBIQ	POS Plan CBHX
Select One: _____Employee Only $0 PP _____Family Coverage $135 PP	Select One: _____ Employee Only $43.03 PP _____ Family Coverage $219.83 PP

Waiving Medial Coverage

Employee Signature:	Date (mm/dd/yyyy)

To Be Completed by Employer

Group Administrator Signature:	Date (mm/dd/yyyy)

City of Pine Bluff

Health Plan Enrollment

I acknowledge that I have been educated regarding the **High Deductible Plan with Health Savings Account (HSA)** that I am electing to participate in **effective**_____.

If I elect **Single Coverage**, I understand that I will be responsible for paying the first $2,000 in Medical and Pharmacy claims, ***except*** preventative services.

If I elect **Family Coverage**, I understand that between **ALL** family members covered on the plan, we will be responsible for the first $4,000 in Medical and Pharmacy claims ***except*** preventative services.

I also acknowledge that once I enroll, **NO** changes can be made until Open Enrollment.

Signature_____

Date_____

DELTA DENTAL

ENROLLMENT/CHANGE FORM

Delta Dental of Arkansas
P.O. Box 15965
North Little Rock, AR 72231
E-mail: eligibility@ddpar.com
Fax (501) 992-1890

☐ New Enrollment ☐ Status Change ☐ Address Change ☐ Termination

☐ Dental Only ☐ Vision Only ☐ Dental/Vision ☐ Cobra

Effective Date

Month	Day	Year

Group Number: 2610 2610V

Group Name: City of Pine Bluff

Social Security Number

Subscriber's Identifier (if applicable)

LAST NAME: _____ FIRST: _____ MI: ____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____

Date of Birth / / MM DD YY

Marital Status ☐ Single ☐ Married

Sex ☐ Male ☐ Female

Date of Hire / / MM DD YY

NOTE: Certain medical conditions may entitle you and/or your covered dependents to additional benefits. Please mark any conditions that apply to you (Under section 2 below, please enter Code for affected dependents in the box entitled "EBD Code." Enter P for pregnant, D for diabetes, and H for Heart Disease)

☐ Pregnancy - Expected due date _____

☐ Diabetes - Date of onset _____

☐ Heart Disease - Date of onset _____

1. COVERAGE CHANGES

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

Type coverage selected (choose one)

Dental	Vision
☐ Employee	☐ Employee
☐ Employee/Spouse	☐ Employee/Spouse
☐ Employee/Child	☐ Employee/Child
☐ Employee/Children	☐ Employee/Children
☐ Employee/Family	☐ Employee/Family

☐ Add Dependent(s) **listed below**
☐ Remove Dependent(s) **listed below**
☐ Name Change
☐ Late Entrance (employee)

Reason(s) for Change:
☐ Marriage
☐ Divorce
☐ Birth or adoption of child
☐ Full Time Student
☐ Handicapped
☐ Other _____

☐ COBRA effective date _____

☐ Change Coverage
☐ Address Change only
☐ Qualifying event
☐ Late Entrance (dependent)

Date of event _____
☐ Loss of spouse's coverage
☐ No longer dependent child
☐ Death of dependent
☐ No longer Full Time Student

2. LIST ALL MEMBERS TO BE ENROLLED OR AFFECTED BY CHANGE

Dental	Vision	Add	Remove	EBD Code	Onset Date	Last (if different)	First	MI	Relationship	Sex M/F	Birthdate (MM/DD/YY)
☐	☐	☐	☐								
☐	☐	☐	☐								
☐	☐	☐	☐								
☐	☐	☐	☐								
☐	☐	☐	☐								
☐	☐	☐	☐								

3. AUTHORIZATION

authorize dentists, dental office personnel, and other health care professionals and entities to disclose to Delta Dental of Arkansas, its agents and employees (including, without limitation, its claims and customer service personnel) all information necessary to determine (1) eligibility for coverage and (2) covered benefits. This authorization is made for each individual to be enrolled or affected by this change. The authorization is valid for 30 months from the date this form is signed for the purpose of collecting information in connection with enrollment, coverage reinstatement, or requests to change benefits. The authorization is valid for the term of coverage for the purpose of collecting information in connection with claims for benefits. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.

4. CERTIFICATION

certify that the information supplied by me on this form is accurate to the best of my knowledge. 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 have been offered the opportunity to enroll in the dental and/or vision program through Delta Dental; however, **I waive coverage at this time.**
I authorize payroll deductions.

Signature: _____ Date:

enrollment/change/waiver

group insurance form

COBRA: If individual is a continuee
Qualifying Event _____
Date of Event _____

AMERITAS LIFE INSURANCE CORP.
P.O. Box 30284
Tampa, FL 33630-3284
877-803-5357 / Fax: 877-457-2201

Policy and Div. # 010-407-615-1 Cert. # _____

Name and Address of Employer (Policyholder) City of Pine Bluff

1 to enroll ☐ Dental ☐ Eye Care ☐ To terminate all coverages VSP Vision Plan

employee information

Marital Status ☐ Single ☐ Married ☐ Civil Union* ☐ Domestic Partner* *As defined by state law or your Group.

Social Security number _____ Dept. number _____

Employee's last name, first name, MI _____

Date of birth _____ ☐ Male ☐ Female

Full time date of hire _____ ☐ Rehire: Rehire date _____

Occupation _____

Hours worked each week _____ Are your earnings paid: ☐ Hourly or ☐ Salaried

Street address _____ City _____ State _____ ZIP _____

E-mail address (limit of 60 characters) _____

Are you covered under another dental insurance plan? . . . . . Employee: ☐ Yes ☐ No Dependents: ☐ Yes ☐ No

Are you covered under another eye care insurance plan? . . . . . Employee: ☐ Yes ☐ No Dependents: ☐ Yes ☐ No

dependent coverage information List all eligible dependents to be added or deleted. (Employee must be enrolled to cover dependents)

print full legal name (last, first, MI)	dental add	eye care add	dental drop	eye care drop	relationship	sex	date of birth	social security no.	college student?
1									
2									
3									
4									
5									

please sign (employee/policyholder) The certificate provides dental and eye care benefits only. Review your certificate carefully. As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. *THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:* I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

X _____ Employee Signature (do not print) Date

X _____ Policyholder Signature (do not print) Date

Agent name _____ Agent # _____ Agent License # _____

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (State-specific statements on back.)

Employee late entrant date _____

Dependent late entrant date _____

Effective Date	Class	Dep. Code

2 to change

☐ Name change New Name _____ Old Name _____

☐ Add dependent coverage

☐ If due to marriage, what is the date of marriage? _____ ☐ If due to birth/adoption, what is the date of event? _____

☐ If due to loss of coverage, date and reason: _____

☐ If other, the date of event and please explain: _____

☐ Drop dependent coverage Number of dependents still covered: _____ Effective date of drop: _____

☐ Due to divorce ☐ Due to death ☐ Due to annual election period ☐ Exceeds maximum age to qualify as dependent

☐ Other (please explain) _____

3 to waive IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION. THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER. I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:

☐ myself (does not apply to TRUST policies) ☐ spouse/domestic partner ☐ child(ren) only ☐ spouse/domestic partner and child(ren)

ecause _____

ame of insurance company and employer of dependent _____

hould I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.

CITY OF PINE BLUFF, ARKANSAS

DEPARTMENT OF HUMAN RESOURCES
200 East 8th Avenue, Suite 104
Pine Bluff, Arkansas 71601
(870) 730-2038
Fax (870) 730-2157

JRMC Wellness/JRMC White Hall Health Center Form

Employee Name: _____

Employee ID #: _____ Department: _____

☐ New Enrollment ☐ Transfer from Public to Corporate Rate

☐ Cancellation of Membership (Complete form in its entirety, incomplete forms will not be processed.)

I authorize a deduction from my bi-weekly earnings for participation in the JRMC Wellness Center as outlined below. Deductions will be made on a bi-weekly basis.

Upon completion, please take this form to the Wellness Center facility and pay the initial joining fees listed below. The Wellness Center will return the form back to the City of PB.

Joining Fees:

Adult Joining Fee $25.00 Payable to the Wellness Center at time of enrollment
Child Joining Fee $10.00 Payable to the Wellness Center at time of enrollment

Check One:	***Membership Type:***	***Monthly Rate:***
☐	Individual only	$40.00
☐	Individual + 1	$50.00
☐	Individual + 2	$55.00
☐	Individual + 3	$60.00
Total		_____

ALL MEMBERS MUST BE PRESENT AT TIME OF REGISTRATION.

At anytime membership is cancelled with the JRMC Wellness Center, a cancellation form must be completed in the Human Resources Department, **prior** to the 15th of the month. Cancellation after the 15th of the month will result in dues deducted for the following calendar month. HR will fax cancellation requests to JRMC upon receipt.

Payroll Effective Date: _____

Employee Signature/Date: _____

JRMC Wellness Center/Date: _____

City of Pine Bluff HR/Date: _____

Submit form to: JRMC Wellness Center 1301 W. 40th Ave., Pine Bluff, AR 71603
Phone: 870-541-7890 / Fax: 870-541-7326

ENROLLMENT FORM FOR GROUP INSURANCE

Group ID: **City of Pine Bluff**	Group Policy#: **892730**	Billing Division or Location:	
Employee Information (Complete for ALL Enrollments)			
Employer Name/ Company Name **City of Pine Bluff**	County **Jefferson**	Employer ZIP **71601**	State **AR**
Employee First Name / Middle Initial / Last Name		Social Security Number	Date of Birth
Street Address / City/State Zip			
Gender:	Marital Status:	Home Phone	Cell Phone	Work Phone
Employee Work Information (Complete for ALL Enrollments)				
Average Work Week:	Occupation:	Earnings:	Date of Full-Time Employment	Rehire Date:
Product Selection (Complete for ALL Enrollments)				
Basic Coverage NOTE: Please mark the box or boxes for all coverages you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy.				
Class	Effective Date	Type of Coverage	Amount of Coverage	Premium
Voluntary Coverage NOTE: Please mark the box or boxes for each coverage you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy.				
Type of Coverage	Selecting yes authorizes my employer to payroll deduct premiums(s)		Amount of Coverage	Monthly Deduction
Short Term Disability Provided By: The Hartford	☐Yes ☐No*			
Long Term Disability Provided By: The Hartford	☐Yes ☐No*			

*By selecting No, application for coverage at a later date may require further medical information and/or physical exam, which will be at my own expense. Actual deductions may vary slightly from above illustration due to rounding.

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.

Signature Section:

I acknowledge I have received and reviewed enrollment materials explaining the benefits offered and the exclusions, limitations and reductions that apply. I understand that the effective date of coverage will vary based on contract terms. I have indicated my elections above authorize my Employer to reduce my paycheck in an amount equivalent to the required contribution for the benefits I have elected. I understand that my payroll deduction amount will change I my coverage or costs change. I understand that the elections I have made will remain in effect for the entire Plan year and may be changed only at the annual enrollment period or within 31 days of a qualifying event or change in family status.

On behalf of myself and as agent of my spouse and all my named dependents, if any, I hereby authorize the release of all medical information and/or records in the possession of any health care provider, insurance company, or other person and/or company or its agents. The release shall continue to be in effect for the duration of my coverage and so long as necessary to determine benefits provided by the program. I represent that the information provided on this form is correct and complete to the best of my knowledge and that I have read and do herby agree to the conditions of enrollment set forth above.

Employee Full Name: _____

Employee Signature: _____ Date: _____

THE

Allstate Voluntary Benefits Enrollment for the City of Pine Bluff

The value of voluntary supplemental insurance can be measured during a time of need - an accident, a disabling injury, an illness or death. Allstate Benefits provides the right voluntary insurance products - health, life, disability, vision and dental - that can be customized with various levels of coverage. Everyone should be able to access quality insurance from a company they trust.

How do I sign up? It is easy to enroll. Contact a Benefit Representative to review the information. You can also **contact Santa Cruz Insurance Group** for enrollment support, **at 1-228-463-0033, ext 21.**

Paying for Coverage: These plans are paid by the employee through payroll deduction.

Employees must have information about dependents & beneficiaries in order to enroll family members- so have that information available when you call: Date of Birth, Socials, Medications taken (prescription information), Doctors name if under a doctors care.

What are the plans and why would I need them?
The following are the benefits available to you through The City of Pine Bluff:

Critical Illness
Accident
Cancer
Universal Life
Term Life

Critical Illness Insurance provides a lump sum benefit which is paid directly to you upon diagnosis with one of the covered critical illnesses. You can choose benefit amounts of $10,000 up to $20,000 and benefits are paid directly to you regardless of any other health coverage you may have and are portable at the same rate.

Accident Insurance pays benefits directly to you, regardless of any other health coverage you have. This plan itemizes your injury and pays according to a schedule of benefits.

Example:	Visit to the Emergency Room	500.00
	Broken Arm	2,145.00
	Ambulance	200.00
	Initial Hospitalization	1,000.00
	Follow Up Visit (2)	50.00

Cancer Insurance provides scheduled benefits for the treatment of Cancer. Benefits included First Occurrence which is a lump sum payment upon diagnosis. Other benefits include; Chemotherapy and Radiation Treatment, hospitalization, surgery, travel, lodging, etc.

Universal Life Insurance is a permanent life coverage in which premiums remain the same throughout the life of the policy and plan does not terminate after the "term" expires. This plan allows you to choose coverage amounts up to $150,000.

★ Mandatory life insurance – City pays!

Lincoln Financial Group®

The Lincoln National Life Insurance Company
P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type | GROUP ID: 65472 | GROUP POLICY #: 00012AS00012 | OFFICE CODE: | Memo

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print)			County	State
City of Pine Bluff			JEFFERSON	AR
Social Security Number	Last Name	First Name	MI	
Street Address	City	State	Zip	Date of Birth
☐ Male ☐ Female	Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed	Spouses Date of Birth	Home Phone ( )	Work Phone ( )

Completed By Employer

Effective Date:	Date of Full-Time Employment:	Occupation:
Earnings: $ ☐ Hourly ☐ Monthly ☐ Weekly ☐ Yearly	☐ Union ☐ Exempt ☐ Non-Union ☐ Non-Exempt	Average Hours Worked Per Week: / Rehire Date:

B. Product Selection (Complete for ALL Enrollments)

Class	Effective Date	Basic Amount *Employer to Complete*	NOTE: Please mark each box if you are eligible for the listed coverage. Coverage		Amount
			Group Life	☑ Yes ☐ No	
			Group AD&D	☑ Yes ☐ No	
			Dependent Life	☐ Yes ☐ No	
			Optional Employee Life	☐ Yes ☐ No	
			Optional Dependent Life	☐ Yes ☐ No	
			Optional AD&D	☐ Yes ☐ No	

C. Beneficiary Information (Complete ONLY for Life or AD&D Enrollments)

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address	City		State	Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address	City		State	Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

D. Signature (Complete for ALL Enrollments)

I hereby apply for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. I reserve the right to revoke this deduction at any time on written notice.

Employee Signature _____ Date Signed _____

Dental Enrollment is on the back of this Enrollment Form.

GLAD 4

Lincoln Financial Group®

Beneficiary Designation Form

The Lincoln National Life Insurance Company
PO Box 2649, Omaha, NE 68103-2649
toll free (800) 423-2765 Fax (800) 462-4660
www.LincolnFinancial.com

Policyholder/Employer	Policy Number(s)
Employee Name	Employee Social Security or Certificate Number
Employee Address (Street, City, State)	Employee Telephone Number

WHO ARE YOUR BENEFICIARIES?

It is very important to clearly indicate your primary beneficiary(ies) and contingent beneficiary(ies). Proceeds are paid to contingent beneficiary(ies) only if there is no surviving primary beneficiary(ies). If multiple primary beneficiaries or contingent beneficiaries are named and no percentage distribution is noted, then any proceeds payable to such beneficiaries will be split equally. If more space is needed to list your beneficiaries please attach a sheet to this form. **The beneficiary(ies) named on this form will be valid for all basic, optional, and/or voluntary group term life and AD&D, Accident and Critical Illness coverages unless otherwise indicated by you. The beneficiary designation may not go into effect until this form is signed and dated by you. Page 2 of this form includes examples of how to complete this form.**

PRIMARY BENEFICIARY(IES)

Primary Beneficiary's Name and Address	Social Security Number	Relationship to You	Date of Birth	Percentage: Must equal 100%
Name: Address:				
Name: Address:				
Name: Address:				

CONTINGENT BENEFICIARY(IES): Contingent beneficiaries will only receive benefit if there are no surviving primary beneficiaries.

Contingent Beneficiary's Name and Address	Social Security Number	Relationship to You	Date of Birth	Percentage: Must equal 100%
Name: Address:				
Name: Address:				
Name: Address:				

Community Property State Consent for residents of Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin. If you are married, live in a community property state, and name someone other than your spouse as beneficiary, you may have your spouse sign below to waive his or her rights to any community property interest in the benefit.

As the Insured's spouse, I do hereby consent to the beneficiary designation(s) indicated on this form and waive any rights that I may have to the proceeds of such insurance under applicable community property laws.

Signature of Spouse _____ Date _____

Signature of Employee _____ **Date** _____