2024	Effective Date:
_____ New Applicant _____ Updating Information _____ Updating General _____ Transferring to a different plan _____ Terminate Coverage _____ Adding/Removing Dependent(s)	UnitedHealthcare DELTA DENTAL ManhattanLife.

General Information

Name: Last First MI	Social Security Number:
Street Address: City State Zip Code	Marital Status: _____ Seperated _____ Single _____ Divorced _____ Widowed _____ Married Date of Marriage: / /

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

General Member Information (please fill out information below for any family members to be covered)

Name (Last, First MI)	SSN#	Date of Birth	Sex	Full Time Student?
Self (Employee)		/ /		
Spouse		/ /		
Child		/ /		Yes No
Child		/ /		Yes No
Child		/ /		Yes No

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

[redacted]	POS Plan CBHX
Select One: _____ Employee Only $15 Per Pay Period _____ Family Coverage $141.75 Per Period	**Select One:** _____ Employee Only $45.18 Per Pay Period _____ Family Coverage $230.82 Per Pay Period
_____ Waving Medical Coverage	

[redacted]	Delta Vision 976 Plan
Select One: _____ Employee Only $0.00 Per Pay Period _____ Family Coverage $24.88 Per Pay Period	**Select One:** _____ Employee Only $3.48 Per Pay Period _____ Family Coverage $8.00 Per Pay Period
_____ Waving Dental Coverage	_____ Waving Vision Coverage

[redacted]
Select One: _____ Employee Only: $14.99 Per Pay Period _____ Family Coverage: $27.10 Per Pay Period
_____ Waiving Cancer Coverage

Employee Signature:	Date (mm/dd/yyyy)

To Be Completed by Employer

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

City of Pine Bluff

High Deductible 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 $2000 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 $4000 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_____

enrollment/change/waiver Group Insurance Form

Ameritas Life Insurance Corp. P.O. Box 81889 / Lincoln, NE 68501-1889 / 800-659-2223 / Fax: 402-467-7338

Ameritas.

Policy and Div. # 010- 407·615·1

Cert. # _____

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

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	Dental drop	Eye Care add	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**

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)**

because _____

Name of insurance company and employer of dependent _____

Should 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:	Group Policy #:	**Please Select Billing Location**
City of Pine Bluff	**GLT 892730**	**015964890002 – COPB** **015964890001 - Wastewater**

Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name	County	Employer ZIP	State
City of Pine Bluff	**Jefferson**	**71601**	**AR**

Employee First Name / Middle Initial / Last Name	Social Security Number	Date of Birth

Street Address / City / State / Zip

Gender:	Marital Status:	Home Phone	Work Phone

Employee Work Information (Complete for ALL Enrollments)

Average Work Week:	Occupation:	Earnings:	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 premium(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 and 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 if 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 any and 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 hereby agree to the conditions of enrollment set forth above.

Employee Full Name: _____ Date: _____

Employee Signature: _____ Date: _____

Waive: _____ Date: _____

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

BASIC LIFE AND AD&D IS FREE TO ALL EMPLOYEES

ENROLLMENT FROM FOR GROUP INSURANCE

GROUP ID: 65472				GROUP POLICY#: 00012AS00012	
A. Employee Information (Complete for ALL Enrollments)					
Employer Name (Please Print)			County: Jefferson	State: AR	
Social Security Number	Last Name	First	M.I.		
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 FT Employment	Occupation			
Earnings $_____ ☐ Hourly ☐ Monthly ☐ Weekly ☐ Yearly	☐ Exempt ☐ Non-Exempt	Average Hours Worked Per Week: _____ Rehire Date _____			

B. Product Selection (Complete for ALL Enrollments)				
Class	Effective Date	Basic Amount	NOTE: Please mark each box if you are eligible Coverage	Amount
			Group Life ☒ Yes ☐ No	
			Group AD&D ☒ Yes ☐ No	
			Dependent Life ☐ Yes ☐ No	
			Optional Employee Life ☐ Yes ☐ No	

C. Beneficiary Information (Complete ONLY for Life or AD&D Enrollments)			
Primary Beneficiary's Last Name First MI	Relationship to Beneficiary	Social Security Number	
Street Address City State Zip			
Contingent Beneficiary's Last Name First MI	Relationship to 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 would like to designate more than one Primary or Contingent, please attach separate sheet of paper.			

D. Signature

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 reduction at any time on written notice.

_____ Employee Signature

_____ Date Signed

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

VHO ARE YOUR BENEFICIARIES?

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

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%
ne: lress:				
ne: ress:				
ne: ress:				

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

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

ture of Spouse _____ Date _____

ature of Employee _____ Date _____