2025 ARBenefits State Employee Retirement Packet

Employee Benefits Division · ARBenefits
PO Box 15610 · Little Rock, AR 72231
Phone: 877-815-1017 Fax: 501-682-1200

Revised: 4.21.2025


ARKANSAS DEPARTMENT OF
TRANSFORMATION AND SHARED SERVICES
AR

Eligibility

To be eligible for ARBenefits retiree coverage:

1. Employees hired before July 1, 2022, must be an active member of the ARBenefits plan on the last day of their employment; and begin drawing an annuity through their participating retirement system.

OR

2. Employees hired after July 1, 2022 – June 30, 2025, must have five (5) cumulative years enrolled on the ARBenefits plan; and begin drawing an annuity through their participating retirement system.
    - Effective July 1, 2025, employees hired after July 1, 2022 must have five (5) cumulative years enrolled on the ARBenefits plan before retirement; and are vested members one of the participating retirement systems (see below), and are retired as determined by one or more of those retirement systems.

Former employees are held to the retirement eligibility rules in place when they left employment.

They have thirty (30) days to enroll in retiree coverage after meeting above criteria 1 - 2 listed above.

If you gain other group coverage upon ending your employment with the State due to retirement, you must enroll within thirty (30) days of losing that coverage.

Retirements Systems

- The Arkansas Public Employees' Retirement System,
    - including the members of the legislative division and the contract personnel of the Arkansas National Guard;
- The Arkansas Teacher Retirement System;
- The Arkansas State Highway Employees' Retirement System;
- The Arkansas Judicial Retirement System; or
- An alternate retirement plan as defined in § 24-7-202.

Non-Medicare Retirees

If you are not yet eligible for Medicare, you can remain on ARBenefits health insurance.

You must notify your agency of your retirement from the state, so they can terminate your active coverage. You can elect to continue working or become a dependent on your spouse's coverage. Once you lose that coverage you will have thirty (30) days to enroll in an ARBenefits retirement plan.

Pre-65 Non-Medicare Retiree Plan Options

Non-Medicare retirees can enroll in either the Premium, Classic, or Basic Plan. These are the same plans offered to active members.

	Premium	Classic	Basic
Individual Deductible	$500	$2,500	$6,450
Family Deductible	$1,000	$3,300/$5,000	$12,900
Individual Out-of-Pocket	Medical: $3,000 Pharmacy: $3,100	$6,450	$6,450
Family Out-of-Pocket	Medical: $6,000 Pharmacy: $3,100	$12,900	$12,900
Doctor's Office Visit	$25 copay	20% after deductible	0% after deductible
Specialist Office Visit	$50 copay	20% after deductible	0% after deductible
Urgent Care Visit	$100 copay	20% after deductible	0% after deductible
In-Patient Services	20% after deductible	20% after deductible	0% after deductible
Out-Patient Services	20% after deductible	20% after deductible	0% after deductible
Wellness Exams/Preventative Care	$0	$0	$0

Medicare Retirees

Medicare eligible retirees can select from the two Medicare plans with ARBenefits starting the first month of Medicare eligibility.

Ninety (90) days prior to turning sixty-five (65), you will receive a Pre-65 Election Request Letter. You must submit your completed Retiree Election Form and all other required documentation to EBD forty-five (45) calendar days from the date of the Election Request letter.

To enroll in Medicare Part A & Part B and learn more, you can:

- Visit https://www.medicare.gov
- Call 1-800-MEDICARE (1-800-633-4227)

You must provide EBD with a copy of your Medicare card showing the start date(s) of your Medicare Part A & Part B.

Medicare Retiree Plan Options

Medicare-eligible retirees can enroll in either the ARBenefits Medicare Advantage Prescription Drugs (MAPD) Group PPO Plan with United Healthcare or the ARBenefits Medicare Primary Plan with Health Advantage.

Option 1 Provided by UnitedHealthcare

The ARBenefits UHC MAPD plan differs from other Medicare plans you might see advertised and is designed specifically for our state and public school Medicare-eligible retirees. The ARBenefits UHC MAPD plan includes the benefits of Medicare Part A, B, and D (you cannot enroll in a separate Part D plan under this option).

Additional benefits include:

- The ability to see any provider (in or out of network) as long as they accept Medicare
- Free gym memberships
- Enhanced hearing and vision benefits
- Dental coverage
- Drug coverage with drug list managed by UHC

For more information:

- Call UnitedHealthcare: 1-844-488-3953
- Visit: www.transform.ar.gov/employee-benefits/retirees/medicare-advantage

IMPORTANT: You can only be enrolled in ONE (1) Medicare Advantage Plan or ONE (1) Medicare Prescription Drug Plan (Medicare Part D) at a time. If you enroll in ANY other Medicare Advantage or Medicare Part D plan, you will AUTOMATICALLY be disenrolled from the ARBenefits UHC MAPD Group Plan and lose the benefits you have selected.

Option 2 Provided by Health Advantage

The Health Advantage Medicare Primary Plan coordinates with your Medicare Part A & B benefits.

Arkansas State Employee Medicare retirees have prescription drug coverage under the Health Advantage Plan and do not have to enroll in a separate Part D plan. The drug list for this plan is managed by Navitus Health Solutions.

EBD will pay your physician claims like you have Medicare Part B coverage, even if you choose not to participate in Part B. See below.

For more information, contact EBD at 1-877-815-1017.

Remember: If you cancel your ARBenefits retirement coverage to leave the plan for any reason OTHER than gaining employment with an Arkansas state agency or an Arkansas public school district, that cancellation is FINAL and you cannot return to the ARBenefits plan.

Coordination of Benefits with Medicare

The Health Advantage Medicare Primary Plan will coordinate as if Medicare Part A and Part B are both in force at the time of service. If you do not have Medicare Part B, the Plan will pay as though you have Medicare Part B, and you will be responsible for any incurred claims.

Medicare Part A (hospital insurance) does not usually require recipients to pay a monthly premium. Medicare Part A includes coverage for:

- Inpatient hospital stays
- Hospice care
- Skilled nursing facility care
- Some home health care

Medicare Part B (physician insurance) is optional and usually requires a monthly premium. Medicare Part B includes coverage for:

- Certain doctor services
- Outpatient care/Medical supplies
- Preventative services

Examples of patient responsibility/liability with and without Medicare Part B:

Your payment with Medicare Part B
Office visit: $150
Medicare approved: $110
Medicare payment: $88
Medicare write-off: $40
ARBenefits payment: $22
Member amount due: $0

Your payment without Medicare Part B
Office visit: $150
Medicare approved: $110
Medicare payment: $0
Medicare write-off: $40
ARBenefits payment: $22
Member amount due: $88

Medicare Part C (Medicare Advantage) is another Medicare health plan choice that provides all of your Part A and Part B coverage and many also provide Part D. Medicare pays a fixed amount to companies offering Medicare Advantage Plans and they must follow the rules set by Medicare.

Medicare Part D is a prescription drug plan that can be provided under a Part C plan or sold by private insurance companies.

Part D coverage is included in the UHC MAPD plan and if you sign up for a Part D plan while on the MAPD plan you will be kicked off and not permitted to return to any ARBenefits plan.

State retirees can maintain drug coverage through ARBenefits or a Part D plan if enrolled on the Health Advantage Medicare Primary Plan. If you elect separate Part D coverage and have the state's pharmacy benefits, you will be responsible for any Part D repayment request from ARBenefits.

Retiree Open Enrollment

You are only allowed to change plans during the Retiree Open Enrollment Period. You are not permitted to add any other dependents as part of Open Enrollment.

If you do not wish to make any changes to your plan during Open Enrollment, then no update is needed from you.

Any changes made during Open Enrollment with take effect January 1 of the following year.

Life, Dental, and Vision Care

Life Insurance

If you want to continue any Colonial Life coverage in retirement you must submit the Colonial Life Election Form. If Colonial Life does not receive your election within thirty-one (31) days after your retirement date, then you cannot regain that coverage later.

The Arkansas State Employee Benefit Advisors (ARSEBA) has more options for life insurance coverage for retirees. Contact them to discuss those options at 501-224-5234.

Dental and Vision

Dental and vision are also provided through ARSEBA. For more information or to enroll, visit www.mysmilecoverage.com/SOAR.

For retirees on the UHC MAPD Plan, dental and vision coverage includes an annual eye exam, a $150 annual allowance for glasses or contacts (not related to cataract surgery), and limited preventative dental care (review plan for allowances). UHC MAPD Plan members are allowed to enroll in additional dental and vision coverage.

Completing the Retiree Election Form

Eligible retirees can begin submitting the Retiree Election Form thirty (30) days prior to their eligibility date and have until thirty (30) days AFTER the eligibility date to enroll in coverage.

You must submit a Retiree Election Form to EBD in order to be enrolled in retiree coverage.

- These are the individual boxes you will see on the form and what EBD needs for each of them: **Event date:** Your last day of employment.
- **Date annuity begins:** When you start drawing your retirement check. **Action requested:** Enroll in the plan.
- **Retirement system:** Mark the correct retirement system. State employees mark APERS. **Benefit option:** Choose which plan you wish to enroll.
    - If you or your covered spouse is Medicare eligible, you/your spouse can choose from the UnitedHealthcare MAPD or the Health Advantage Primary Plan. Medicare eligibility is determined by age - 65 or older - or by disability. You must include a copy of the Medicare card as soon as possible.
    - If you and your covered spouse are NOT Medicare eligible, you can choose the Health Advantage Premium, Classic, or Basic Plan.
- **Coverage Level:** Retiree only, Retiree and spouse, Retiree and child(ren), or Retiree and Family **Dependents:** Only dependents on your active health plan can be added as dependents on your retirement plan.

Sign and date your form and enter your email address.

Once all eligibility requirements are met and requested documentation is received, the effective date of coverage is the first day of the month following the date EBD receives your completed application for your retirement health insurance.

Example: If EBD receives completed forms on 2/15, then coverage will begin on 3/1.

Arkansas Law allows retirees a one-time option to enroll in the State and Public-School Retirement Health Plan. Enrollment is either at the time of eligibility or delayed enrollment due to current coverage on an employer-sponsored group health plan with a qualifying event of involuntary loss of coverage. Once you leave the ARBenefits retirement plan, you will no longer be eligible for participation in the plan. This decision is FINAL.

Once you become eligible for Medicare, you must provide EBD with a copy of your Medicare card, indicating the start dates of both Medicare Part A and Part B coverage.

EBD may also request updated documents to maintain eligibility for our records.

This packet contains additional forms that may require your attention, including:

- **Retiree Election Form:** The general form that all retirees must complete to select coverage.
- **Authorization to Release Information:** Allows authorization for another individual to access your medical information. If you have a Power of Attorney (POA) on file, you do not need this form.
- **ARBenefits Spousal Affidavit:** This must be completed to add your spouse to the plan. **Colonial Life Retiree Deduction Authorization:** If you want to continue with Colonial Life coverage with the state, you must complete this form.
- **Dental and Vision Form:** These must be completed to add retirement dental and/or vision coverage.
- **Bank Draft Authorization Form:** If your annuity is not enough to cover your premium or if you would like your premiums drafted from your bank account, you will need to submit this form. If you choose to have your premium drafted from your bank account, you must include a second, voided check along with the Bank Draft Authorization Form.

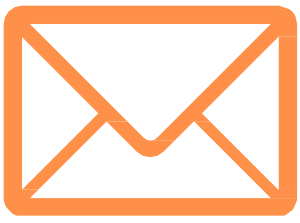
Payment

EBD requires a check payment as the initial payment for retirement insurance.

If you choose to have your premiums taken from your annuity, it will begin the second month of coverage.

You can choose to have premium payments come out of your bank account or your annuity at any time.

Contact EBD with any additional questions



P.O. Box 15610
Little Rock, AR 72231

877-815-1017

Ask.EBD@arkansas.gov

Other Contact information

Phone: 501-682-7800
Toll Free: 800-682-7377
Website: www.apers.org

Phone: 501-224-5234
Fax: 501-663-1445
Toll Free: 800-682-7377
Email: service@arseba.com
Website: www.apers.org

Phone: 501-683-3151
Toll Free: 800-525-4368
Website: www.coloniallife.com

Phone: 501-301-9900
Website: www.voya.com

Phone: 800-633-4227
Website: www.Medicare.gov

Phone: 800-772-1213
Website:

RATES


ARKANSAS DEPARTMENT OF
TRANSFORMATION AND SHARED SERVICES
AR

ARKANSAS STATE NON-MEDICARE RETIREE MONTHLY PREMIUMS

RATES EFFECTIVE JANUARY 1, 2025 – DECEMBER 31, 2025

PLAN	BASE MONTHLY PREMIUM	STATE & PLAN CONTRIBUTION	TOTAL MONTHLY RETIREE COST
PREMIUM			
RETIREE ONLY	$1,028.60	$690.74	$337.86
RETIREE & NON-MEDICARE SPOUSE	$2,057.19	$1,170.43	$886.76
RETIREE & CHILD(REN)	$1,411.46	$792.26	$619.20
RETIREE & NON-MEDICARE SPOUSE & CHILD(REN)	$2,440.05	$1,339.89	$1,100.16
RETIREE & MEDICARE PRIMARY SPOUSE	$1,579.57	$881.97	$697.60
RETIREE & MEDICARE PRIMARY SPOUSE & CHILD(REN)	$1,962.43	$983.79	$978.64
RETIREE & MAPD PRIMARY SPOUSE	$1,248.91	$889.42	$359.49
RETIREE & MAPD PRIMARY SPOUSE & CHILD(REN)	$1,631.77	$991.16	$640.61
CLASSIC			
RETIREE ONLY	$894.23	$676.77	$217.46
RETIREE & SPOUSE	$1,788.46	$1,151.94	$636.52
RETIREE & CHILD(REN)	$1,227.09	$783.05	$444.04
RETIREE & FAMILY	$2,121.32	$1,326.12	$795.20
BASIC			
RETIREE ONLY	$789.25	$666.35	$122.90
RETIREE & SPOUSE	$1,578.50	$1,139.54	$438.96
RETIREE & CHILD(REN)	$1,083.03	$777.19	$305.84
RETIREE & FAMILY	$1,872.28	$1,318.26	$554.02
The Basic Plan meets the minimum essential coverage required under A.C.A.			

State Contribution is funded by legislation.

Plan Contribution is funded by ASE Trust Fund as Claims Reserve Allocation.

AR BENEFITS

ARKANSAS STATE MEDICARE UNITEDHEALTHCARE (UHC) MAPD GROUP RETIREE MONTHLY PREMIUMS (MEDICAL & PHARMACY)

RATES EFFECTIVE JANUARY 1, 2025 – DECEMBER 31, 2025

MEDICARE ELIGIBLE	BASE MONTHLY PREMIUM	STATE & PLAN CONTRIBUTION	TOTAL MONTHLY RETIREE COST
MAPD RETIREE ONLY	$220.31	$198.28	$22.03
MAPD RETIREE & NON-MEDICARE SPOUSE	$1,248.90	$678.71	$570.19
MAPD RETIREE & CHILD(REN)	$603.17	$300.70	$302.47
MAPD RETIREE & MAPD CHILD	$440.62	$396.56	$44.06
MAPD RETIREE & NON-MEDICARE SPOUSE & CHILD(REN)	$1,631.76	$848.23	$783.53
MAPD RETIREE & NON-MEDICARE SPOUSE & MAPD CHILD	$1,469.21	$876.99	$592.22
MAPD RETIRE & MAPD SPOUSE	$440.62	$396.56	$44.06
MAPD RETIREE & MAPD SPOUSE & CHILD(REN)	$823.48	$499.44	$324.04
MAPD RETIREE & MAPD SPOUSE & MAPD CHILD	$660.93	$594.84	$66.09

State Contribution is funded by legislation.

Plan Contribution is funded by the ASE Trust Fund as Claims Reserve Allocation.

ARKANSAS STATE MEDICARE PRIMARY RETIREE MONTHLY PREMIUMS

RATES EFFECTIVE JANUARY 1, 2025 – DECEMBER 31, 2025

MEDICARE ELIGIBLE	BASE MONTHLY PREMIUM	STATE & PLAN CONTRIBUTION	TOTAL MONTHLY RETIREE COST
RETIREE ONLY	$550.97	$294.63	$256.34
RETIREE & NON-MEDICARE SPOUSE	$1,579.56	$773.88	$805.68
RETIREE & CHILD(REN)	$933.83	$396.05	$537.78
RETIREE & NON-MEDICARE SPOUSE & CHILD(REN)	$1,962.42	$943.38	$1,019.04
RETIREE & MEDICARE PRIMARY SPOUSE	$1,101.94	$487.83	$614.11
RETIREE & MEDICARE PRIMARY SPOUSE & CHILD(REN)	$1,484.80	$588.26	$896.54

State Contribution is funded by legislation.

Plan Contribution is funded by ASE Trust Fund as Claims Reserve Allocation.

FORMS

ARBENEFITS

State & Public-School Retirement Election Form

Employee Information

Legal First Name	MI	Legal Last Name	Date of Birth	Gender ☐M☐F	Social Security Number

Mailing Address	City	State	Zip Code

Physical Address

Event	Event Date	Date Annuity Begins	Home/Cell Number

Coverage

Type of Action

- ☐ Enroll in the Plan
- ☐ Enroll as a Surviving Spouse
- ☐ Add/Drop Dependents
- ☐ Open Enrollment
- ☐ Cancel Coverage

Choose Retirement System

- ☐ APERS (State) 998
- ☐ APERS (School) 059002
- ☐ APERS Judicial 021
- ☐ Highway Dept. 091
- ☐ ATRS (State) 999
- ☐ ATRS (School) 059001
- ☐ VALIC/TIFF - Alternate Retirement (Bank Draft)

Payment Method

Please complete Bank Draft Authorization Form

- ☐ Annuity
- ☐ Checking
- ☐ Savings

Pre-65 Plan

- ☐ Premium ☐ Basic
- ☐ Classic

Post-65 Plan

- ☐ United HealthCare MAPD
- ☐ Health Advantage Primary

Choose Coverage Level

- ☐ Employee Only
- ☐ Employee & Child(ren)
- ☐ Employee & Spouse
- ☐ Employee & Family

Medicare

OUR PLANS REQUIRE MEDICARE-ELIGIBLE RETIREES TO BE ENROLLED IN BOTH MEDICARE PART A & B.

Add/Drop Dependents

Please check the correct column to ADD a dependent to the plan or DROP a dependent currently covered. Proof of a dependent's eligibility must be submitted with this application for all dependents. To complete the RELATIONSHIP column, use the number that describes the dependent(s). Spouse - 1, Child - 2, Permanent Legal Guardian - 3

ADD	DROP	LEGAL NAME (FIRST, MI, LAST)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MALE	FEMALE	RELATIONSHIP
☐	☐				☐	☐	
☐	☐				☐	☐	
☐	☐				☐	☐	

Subscriber Certification

I authorize deductions of the required contributions (if applicable). I understand that my elections can only be changed during the next open enrollment period or if I have a qualifying event as defined in the ARBenefits Summary Plan Description. I understand I must request such changes within 30 days of the qualifying event. On behalf of myself and anyone enrolled on or added to this form, I authorize any health care professional or entity to give the health plan/insurer or any of their designees, any and all records or information pertaining to medical history or services rendered to the heath plan/insurer, for any administrative purpose, including evaluation of an application or claim. I also authorize on behalf of health plan/insurer the use of a Social Security Number for the purpose of identification. A photocopy of this authorization will be as valid as the original. Please note that falsifying documents, misrepresenting dependent status or using other fraudulent actions to gain coverage may be criminal acts and can lead to permanent termination of coverage. I understand by signing the election form, it means I have read and agree with the attached instruction page and understand the options I chose on the election form.

Employee Signature	Date	Email Address

SUBMISSION TO EBD IS FINAL

Department of Transformation and Shared Services • Employee Benefits Division
P.O. Box 15610 • Little Rock, AR 72231-5610 • Fax: 501-682-1200

Instructions

ALL PORTIONS OF THE ELECTION FORM MUST BE COMPLETED OR IT WILL BE SENT BACK FOR COMPLETION PRIOR TO PROCESSING.

Currently United HealthCare is the provider for the Group Medicare Advantage Plan (MAPD) plan and Health Advantage is the provider for the Medicare Primary Premium Plan. Each Medicare eligible member is required to maintain Medicare Part A & B coverage. A copy of the Medicare card is required for any subscriber and/or spouse/dependent.

ARBenefits Medicare Primary Premium Plan for retirees will coordinate as if Medicare Part A & B are both in force at the time of service. If the member does not have Part B, the plan will pay as though the member does have Part B coverage. The member will have full financial responsibility for incurred claims.

Public School Retirees who choose the Medicare Primary Premium Plan will NOT have pharmacy benefits through this plan. You will be required to obtain Medicare Part D for your pharmacy needs.

If you choose the UnitedHealthCare MAPD Plan and enroll in a separate Medicare plan outside of ARBenefits, you will automatically be canceled from ARBenefits coverage. If you have questions about your coverage, call ARBenefits before making your decision.

The Bank Draft Authorization Form, with VOIDED check attached, is required if your retirement annuity is not able to cover the full cost of your premiums. WE CANNOT PROCESS WITHOUT A VOIDED CHECK.

Your premiums are post-tax.

IF YOU CANCEL YOUR RETIREMENT INSURANCE OTHER THAN BY GAINING EMPLOYMENT WITH A STATE AGENCY OR PUBLIC SCHOOL, YOU WILL NOT BE ABLE TO COME BACK TO THE PLAN AND THE DECISION IS FINAL.

Completion of this form does not guarantee coverage on the retirement plan as certain conditions must be met in order to be enrolled on to either ARBenefits Retirement Plans.

RECIPROCITY SERVICE

- A retiree who is fully vested as a state employee AND fully vested as a public school employee (a participating member under both APERS and ATRS and drawing a retirement annuity from each may choose to enroll in with the ASE or PSE retirement health plan.
- A retiree who is not fully vested under either system, but has enough time between the two systems to be eligible for reciprocity service will be enrolled in the retiree health plan of the system with the most service.

VESTING

- State and Public School retirees changed from a ten (10) year vesting to a five (5) year vesting period effective 7/1/1997.
- Retirees with service prior to 7/1/1997 are still held to the ten (10) year vesting period.
- Non-teaching school retirees that are paid under Arkansas Public Employees Retirement System (APERS) have school rates.
- Most college and county employed retirees are NOT eligible under the State & Public School Retirement Health Insurance. Reciprocity services from these agencies do not make a retiree eligible for the health insurance.

Proof of dependent eligibility is required. Examples of required documentation: birth certificates, marriage licenses, court documents, and a Certificate of Credible Coverage (COCC) for loss of coverage.

If adding dependent as a permanent legal guardian you must include court documents and they will be subject to annual review.

You can also submit documents online through the ARBenefits Member Portal at www.myarbenefits.org/portal.

For assistance, contact ARBenefits at 1-877-815-1017 Monday - Friday, from 8:00AM - 4:30PM CST or email us at Ask.EBD@arkansas.gov.

Learn more about plans, costs, and network providers at www.transform.ar.gov/employee-benefits/retirees/

Coverage is effective the 1st of the month and termed at the end of the month following date of receipt and based on eligibility rules.

MAIL OR FAX FORM AND ACCOMPANYING DOCUMENTS TO:

Department of Transformation and Shared Services - Employee Benefits Division
PO Box 15610, Little Rock, AR 72231-5610 - FAX: 501-682-1200

SUBMISSION TO EBD IS FINAL

BANK DRAFT AUTHORIZATION

I hereby authorize the Department of Transformation and Shared Services - Employee Benefits Division to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debits in error to our bank account indicated at the financial institution listed below, hereinafter called 'Depository', to debit and/or credit the same such account.

First month Retirement and COBRA payments MUST BE MADE BY CHECK OR MONEY ORDER. If first payment is not included, the bank draft will not be setup nor will enrollment be completed.

All COBRA NSF drafts must be paid by the end of the month to avoid termination of coverage.

Select One:

☐ Retirement Effective Date: _____ ☐ COBRA Effective Date: _____

☐ Annuity

☐ Bank Draft

Bank Name: _____

Routing #: _____

Account #: _____

Type of Account	**Date of Draft**
☐ Checking ☐ Savings	☐ 5th ☐ 7th ☐ 15th ☐ 20th ☐ 28th *Not available for COBRA

This authorization shall remain in effect unless the Employee Benefits Division has received written notification from me (us) of its termination in such time and in such manner as to afford the Employee Benefits Division and Depository a reasonable opportunity to act on it.

Authorized Signer on Account: _____
(Please print name clearly)

Authorized Signer Signature: _____
(Authorized Signer) (Date)

Member ID #: _____ Last 4 SSN: _____

Per Arkansas Code Ann. §5-37-301, a $25.00 Return Item Charge fee plus a $2.00 service fee for bank drafts will be assessed per item returned not paid by the bank.

*** Please enclose the first month's payment and MUST have original check or Money Order. No copies or deposit slips can NOT be used.***

MAIL OR FAX FORM AND ACCOMPANYING DOCUMENTS TO:
Department of Transformation and Shared Services - Employee Benefits Division
PO Box 15610, Little Rock, AR 72231-5610 - FAX: 501-682-1200

Affidavit of Spousal Healthcare Coverage

Employee Name		Employee SSN	
Spouse Name		Spouse SSN	

To be completed by employee electing to enroll a spouse or when dropping a spouse due to gaining employer group coverage.

Pursuant to Arkansas Code Ann. §21-5-407(4), any spouse who is offered coverage for Medical Benefits under any other employer-sponsored health plan is NOT eligible to be covered under the ARBenefits Plan.

1. Is your spouse currently employed?

   ☐ Yes (If yes, please proceed to question #2)

   ☐ No (If no, sign and return this form along with your election form and a copy of your marriage license)

2. Is your spouse currently employed by an Arkansas state agency or public school district?

   ☐ Yes (If yes, sign and return this form along with your election form and a copy of your marriage license)

   ☐ No (If no, proceed to question #3)

3. Is your spouse eligible for his/her employer-sponsored group health plan?

   ☐ Yes

   ☐ No (Letter from employer explaining why they are not eligible is required. Spouse will not be added if this is not provided.)

   ☐ My Spouse is self-employed, provide company name: _____

For any questions or concerns, contact EBD at 1-877-815-1017 or email Ask.EBD@arkansas.gov

By signing this affidavit I certify that the information provided above is accurate. I understand that any misrepresentations in the information I provided above will permit the ARBenefits Plan to terminate my coverage. If applicable, I authorize the release of the information noted above and agree to its use in the application process for ARBenefits Plan coverage.

Employee signature: _____ Date: _____

Spouse signature: _____ Date: _____

MAIL OR FAX FORM AND ACCOMPANYING DOCUMENTS TO:
Department of Transformation and Shared Services - Employee Benefits Division
PO Box 15610, Little Rock, AR 72231-5610 - FAX: 501-683-0983

AR BENEFITS Authorization to Release Information

This form is used to release your protected health infomation as required by federal and state privacy laws. Your authorization allows the Employee Benefits Division (EBD) to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to EBD or filling out the Authorization to Revoke Release of Health Information form. Revoking this authorization will not effect any action taken prior to receipt of your written request.

Member Information (individual whose information will be released)

Name: _____ Member ID #: _____

Home Number: _____ Cell Number: _____ Birth date: _____

Address: _____ City: _____ State: _____ Zip: _____

I authorize EBD to release my protected health information as described below

Recipient (Person or Organization that will receive your information)

Person's Name or Organization: _____

Address: _____ Home Number: _____

Person's Name or Organization: _____

Address: _____ Home Number: _____

Description of the Information to be Released

☐ Entire Health Record

☐ Other, please describe _____

This authorization will expire (Check ONLY ONE Box)

☐ When I revoke this authorization

☐ Upon the following date, event, or condition _____

If I fail to select an option above, this authorization will expire in twelve (12) months from the date of this signing.

I understand that this authorization to release information is voluntary and is not a condition of enrollment in the ARBenefits Health Plan, eligibility for benefits, or payment of claims. I also understnad that once the information is disclosed pursuant to this authorization, it may be disclosed by the recipient and the information may not be protected by federal privacy regulations. I understand that the information in my health record may include information relating to sexually transmitted diseases, behavioral or mental health services, and treatment fo alcohol and drug abuse.

By signing below, I authorize the release of my protected health information as described above.

_____ _____

Signature of Member or Legal Representative Date

_____

Printed Name of Member or Legal Representative

MAIL OR FAX FORM AND ACCOMPANYING DOCUMENTS TO:

Department of Transformation and Shared Services - Employee Benefits Division

ATTN: Eligibility Department - PO Box 15610, Little Rock, AR 72231-5610 - FAX: 501-683-0983

Colonial Life

Group Term Life Insurance with Accidental Death & Dismemberment (AD&D) Insurance for Retired* Employees

How secure is your family's financial future without you?

If something happened to you, would your family be able to maintain their way of life? How would they cover ongoing living expenses? Colonial Life's group term life insurance can help provide financial security for your family.

Why is group term life insurance a good option?

- Death benefit protection
- Lower cost option
- Coverage for specified periods of time, which can be during high-need years
- Benefit is typically paid tax-free to your beneficiaries

AD&D insurance provides benefits to help cover the additional expenses associated with an accidental death, as well as the high costs of recovery and rehabilitation required by an accidental dismemberment.

The AD&D full benefit amount is equal to your group term life insurance death benefit amount.

The following benefits are paid under the AD&D benefit:

If the loss is:	% of the full amount paid
Loss of life	100%
Loss or loss of use of both hands or both feet or sight of both eyes	100%
Loss or loss of use of one hand and one foot	100%
Loss or loss of use of one hand and sight of one eye	100%
Loss or loss of use of one foot and sight of one eye	100%
Loss of speech and hearing	100%
Loss or loss of use of one hand or one foot	50%
Loss of sight of one eye	50%
Loss of speech or hearing	50%
Loss of thumb and index finger of the same hand	25%

Additional benefits and services:

Seatbelts and Airbags – Pays if the cause of death or dismemberment is a car accident and if the covered person was using a seatbelt or airbag.

Built-in accelerated death benefit provides an advance of up to 75% of the death benefit, to a maximum of $150,000, if the covered person is diagnosed with a terminal illness.[1]

Health Advocate employee assistance program provides 24-hour confidential personal support and referral service, including a medical bill saver service. Face-to-face sessions and video counseling with mental health professionals are available.[2]

ONLINE
ColonialLife.com/EAP

Telephone
1-888-645-1772

Life planning services offer financial and legal counseling services, as well as grief support and referral for up to 12 months after a claim.[2]

*Includes Arkansas state and public school employees retired after 1/1/2020.

Take action to retain your group term life with AD&D insurance coverage as a retiree.

Within 31 days of your retirement date, submit a group term life with AD&D service form and payment authorization form to Colonial Life via fax at 803-678-6861. The retiree service form and beneficiary designation form are available at https://www.transform.ar.gov/employee-benefits/retirees/.

[1] Terminal illness means an injury or sickness that results in the covered person having a life expectancy of 12 months or less and from which there is no reasonable prospect of recovery.

[2] The Employee Assistance Program and Life Planning Services, provided by Health Advocate, are available with Colonial Life & Accident Insurance Company's Group Term Life offering. Terms and availability of service are subject to change. The service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact the company for full details.

Your basic and optional coverages

Coverage options	Retiree coverage details. Retirees may not increase coverage amounts.
Basic group term life with AD&D insurance**	Upon retirement, coverage is reduced by 50% of the active employee coverage. At age 75, coverage is reduced by an additional 50%.
Expanded basic group term life with AD&D insurance**	Upon retirement, coverage is reduced by 50% of the active employee coverage. At age 75, coverage is reduced by an additional 50%.
Supplemental employee group term life with AD&D insurance **	Upon retirement, coverage is reduced by 50% of the active employee coverage. At age 75, coverage is reduced by an additional 50%.
Supplemental spouse group term life with AD&D insurance	Upon retirement, spouse coverage is reduced by 50% of the active employee coverage. At age 75, spouse coverage is reduced by an additional 50%.
Supplemental dependent child(ren) group term life with AD&D insurance	No coverage reductions to dependent child(ren) coverage

** *At age 75, Basic, Expanded Basic and Supplemental Life Insurance may not exceed a combined face amount of $25,000, comprised of no more than $12,500 of Basic and Expanded Basic combined and no more than $12,500 of Supplemental Life coverage.*

2025 Retiree Rates* (per $1,000) Monthly cost of coverage

Retiree basic and expanded basic group term life with AD&D insurance	
$1.13 per $1,000	
Retiree supplemental group term life with AD&D insurance	
Age	**Employee**
Under 50	**$0.41**
50-54	**$0.66**
55-59	**$0.95**
60-64	**$1.43**
65-69	**$2.78**
70-74	**$ 4.53**
75+	**$ 9.03**
Retiree supplemental spouse group term life with AD&D insurance	
All eligible ages	**$1.28**
Retiree supplemental dependent child(ren) group term life with AD&D insurance	
All eligible ages	**$0.12**

*Includes Arkansas state and public school employees retired after 1/1/2020.

BENEFIT REDUCTION SCHEDULE

Retirees prior to 1/1/2020:

Refer to your certificate for benefit reduction details.

EXCLUSIONS AND LIMITATIONS

Losses Not Covered Under Your Life Insurance Benefit:

Your life insurance benefit does not cover any losses where death is caused by, contributed to by, or results from suicide occurring within 24 months after a covered person's initial effective date of insurance or after the date any increases or additional insurance becomes effective, whether sane or insane.

This applies to any amounts of insurance for which you pay all or part of the premium.

This applies to any amount subject to evidence of insurability requirements and we approve the evidence of insurability form and the amount you applied for at that time.

You will be given credit for any period of time applied toward the satisfaction of the suicide provision, if any, under your Employer's prior group life insurance plan.

Losses Not Covered Under the AD&D Insurance Benefit:

Your AD&D benefit does not cover any losses that are caused by, contributed to by, or resulting from:

- an attempt to commit or commission of suicide or intentional self-inflicted injury while sane or insane;
- active participation in a riot;
- an attempt to commit or commission of a felony or engaging in an illegal occupation;
- voluntary use of any drugs, poisonous substance, intoxicant or narcotic, except any drugs taken as prescribed by a physician and taken as prescribed. Accidental exposure to any poisonous substance will not be excluded;
- the presence of that percentage of alcohol in the covered person's blood which raises a presumption that the covered person was under the influence of alcohol. The blood-alcohol level which raises this presumption is governed by the laws of the state in which the accident occurred;
- disease of the body, mental infirmity or diagnostic, medical or surgical treatment;
- being exposed to war or any act of war, declared or undeclared, or serving in the armed forces of any country or authority. Losses as a result of acts of terrorism or nuclear release committed by individuals or groups will not be excluded from coverage unless the covered person who suffered the loss committed the act of terrorism or nuclear release; or
- investigational or experimental procedures, surgery, or drugs, including complications arising from having experimental or investigative procedures, surgeries, or drugs.

Termination

Coverage terminates:

- if the group policy ends;
- the date you no longer meet eligibility requirements;
- the end of the grace period if we do not receive the required premium for your insurance; or
- the date the next premium is due after you ask us to end your coverage.

Premium will vary based on plan options and face amount.

Applicable to policy number GTL1.0-P-AR-SOA and certificate number GTL1.0-C-AR-SOA.
This is not an insurance contract and only the actual policy provisions will control.

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY, PO BOX 1365, COLUMBIA, SC 29202
STATE OF ARKANSAS RETIREES - GROUP TERM LIFE WITH AD&D SERVICE FORM AND PAYMENT AUTHORIZATION FORM

Retired: ☐ AR State Employee ☐ AR Public School Employee	Retirement Date (mm/dd/yyyy):
Name of District/Agency retired from:	Code of District/Agency retired from:

Retiree Information

Retiree Name (First, MI, Last)	Gender ☐M ☐F	Birthdate (mm/dd/yyyy)	Social Security No.

Home Address – Street	City	State	Zip Code	Member No.

Email Address	Primary Phone No. Secondary Phone No.

List all policies/certificate numbers related to this request (Required to process):

Qualifying Life Event	Event Date
☐ Marriage ☐Legal Separation ☐ Birth or Adoption of Child ☐Death of Spouse ☐ Divorce ☐Annulment ☐ Placement of Child for Adoption ☐Death of Dependent Child	

Service Requested

☐ Cancel Retiree Coverage	☐ Decrease Coverage	☐ Cancel Dependent Child(ren) Coverage	☐ Change Address
☐ Surviving Spouse Coverage Continuation	☐ Cancel Spouse Coverage	☐ Change Name	☐ Change Retiree Premium Payment Method

If adding a spouse or child coverage as a result of a qualifying life event, an Enrollment Form or Evidence of Insurability Form must be completed. If canceling or decreasing coverage, complete Cancel/ Decrease Details below. For all other changes, complete the corresponding section below.

Surviving Spouse Coverage Continuation

Surviving Spouse Name:

Cancel/Decrease Details

Employee and spouse coverages are reduced by 50% of the active employee coverage. At age 75, employee and spouse coverages are reduced by an additional 50%.

Coverage Type	Check only if you wish to cancel or decrease coverage	New Amount of Coverage Requested (required)
Basic Group Term Life and AD&D	☐ Cancel	$5,000
Expanded Basic Group Term Life and AD&D	☐ Cancel ☐ Decrease	$
Supplemental Group Term Life and AD&D	☐ Cancel ☐ Decrease	$
Spouse Supplemental Group Term Life and AD&D	☐ Cancel ☐ Decrease	$
[1]Dependent Child(ren) Supplemental Group Term Life and AD&D	☐ Cancel ☐ Decrease	$

[1]Elected child(ren) coverage includes all eligible dependents. If cancelling, all dependent child(ren) coverage will be removed.

Name Change

Previous:	Current:	Reason: ☐ Marriage/Divorce ☐ [2]Correction ☐ [2]Other

[2]A copy of legal documentation is required unless your name is changing due to reason of marriage or divorce.

Address Change

Home Address – Street	City	State	Zip Code

Email Address	Primary Phone No. Secondary Phone No.

Select the retirement system in which you participate. Always complete. Check only one of the following:

☐ ARDOT RETIREES SOA 091 (E5373097)
☐ APERS STATE RETIREES 998 (E5381462)
☐ ARTRS RETIREES SOA 999,059001 (E5381587)
☐ ARJS STATE RETIREES SOA 021 (E5381488)
☐ APERS SCH RETIREES SOA 059002 (E5381470)
☐ ADJRS STATE RETIREES SOA (E5381496)
☐ STATE OF AR RETIREES to DIRECT BILL (E5381421), check and complete Premium Payment Method Change Section below.

Premium Payment Method Change – If your premiums will not be deducted from your retirement check, please select a payment method

1. ☐ **Please deduct monthly premiums from my bank account.**
   ☐1st - 5th ☐6th - 10th ☐11th - 15th ☐16th - 20th ☐21st - 26th

   Your draft will occur on one of the dates within the range you have selected.
   Please include a voided check or provide:
   Routing # _____ Account #_____

   _____
   Signature of bank account owner (REQUIRED)

2. ☐ Please bill me directly. (Choose one of the following):

   ☐ Quarterly (3 times your monthly premium)
   ☐ Semi-Annual (6 times your monthly premium)
   ☐ Annual (12 times your monthly premium)

IPG for direct pay retiree policies (Internal use only): I2058329

Authorization Section

If this form is not received by Colonial Life & Accident Insurance Company before the monthly pension deduction deadline, a direct bill will be mailed to you. Failure to pay this bill may result in cancelled coverage. Once the initial bill is paid, monthly deductions from your pension check will automatically begin. In the event my retirement annuity does not have sufficient funds for premium deduction, a Bank Draft Authorization form, along with a voided check must be attached. Premiums paid will be post-tax. I understand that my elections can only be changed if I have a qualifying status change event and that I must request such changes within 60 days of the qualifying event.

I hereby authorize you to deduct from my retirement check such amounts as necessary to pay the premiums for my life insurance plan. I further authorize you to pay such amounts to the insurance company providing such insurance or its authorized representative. This authorization remains in effect until you receive notice from me in writing that it has been changed or revoked.

_____ _____

Retiree Signature Date (mm/dd/yyyy)

DELTA DENTAL®

DENTAL AND VISION PLANS

State of Arkansas Retiree Program

Individual and family plans at a price that will make you smile.

WHAT'S COVERED?

PREVENTIVE AND DIAGNOSTIC

- Two routine exams per benefit period
- X-rays
- Two cleanings per benefit period
- Two fluoride applications for dependent children up to age 19
- Sealants for dependent children up to age 16

BASIC RESTORATIVE SERVICES

- Minor emergency treatment
- Fillings
- Simple extractions
- Space maintainers for dependent children up to age 14
- Stainless steel crowns for dependent children up to age 16

MAJOR RESTORATIVE SERVICES

- Crowns
- Endodontics (root canals)
- Oral surgery
- Dentures, bridges, partials

WHY DENTAL INSURANCE?

People with dental insurance typically visit the dentist more often than those without, resulting in better dental and overall health.

Besides keeping your smile healthy, your dentist can also help identify more than 120 signs and symptoms of non-dental diseases —including heart disease and diabetes—before they become larger problems.[1]

Prevention costs less than treatment. Most dental plans, such as Delta Dental Individual and Family, encourage prevention by covering the cost of exams, cleanings, X-rays and more in order to help prevent dental disease rather than to perform expensive, and sometimes painful, restoration work later.

DENTAL PLANS	Delta Dental Dentist	Non-participating Dentist
Individual/family deductible	$50/$150	
Individual benefit-year maximum	$1,500	
What the plan pays for after you have satisfied the deductible		
Preventive & Diagnostic	100%	80%
Basic Restorative Services	80%	60%
Major Restorative Services	60%	50%
Waiting Periods*		
Preventive & Diagnostic	None	
Basic Restorative Services	None	
Major Restorative Services	6 Month	

Monthly Premiums	
Individual Only	$38.98
Individual & Spouse	$77.70
Individual & Child(ren)	$75.86
Individual & Family	$125.72

The dental plans offered in this brochure do not include pediatric dental services as required under the Affordable Care Act (ACA). To learn about Delta Dental's ACA compliant dental plans and assistance to determine if you need an ACA compliant pediatric dental plan, call our representatives at (844) 487-6453 or visit www.deltadentalcoversmysmile.com/s/SOAR.

*Deductible does not apply.

OUT-OF-NETWORK BENEFITS (NON-PARTICIPATING)

Services conducted through an out-of-network dentist will be reduced as indicated above by Delta Dental of Arkansas after applying the applicable deductibles, copayments and maximums. This means your out-of-pocket expense will be more if you choose an out-of-network dentist.

*WAITING PERIODS WILL BE WAIVED IF:

1. Your application is received within 31 days of the termination of your prior carrier.
2. You have had at least six months of continuous coverage in Major Restorative Services.

To waive waiting periods, please submit a copy of your Certificate of Creditable Coverage verifying your previous dental coverage and a copy of your covered benefits.

Delta Dental has the largest network of dentists in Arkansas and across the nation,[2] which means you will find affordable care wherever you are.

1 J Am Dent Assoc, Vol 134, No suppl_1, 41S-48S. 2003 American Dental Association and Dental Management of The Medically Compromised Patient, 8th Edition, 2013, Mosby Elsevier, St. Louis, MO. | 2 Delta Dental Plans Association, web.

TAKE CARE OF YOUR SMILE AND YOUR VISION!

Delta Dental also offers vision insurance when you select an individual or family dental plan.

Vision and eye health problems are the second most prevalent and chronic health care problems in the United States—affecting more than 120 million people. Like dental insurance, vision plans promote routine care, which keeps your eyes healthy and can help detect diseases such as diabetes.

Choose the dental plan that best fits your needs, and add vision to receive coverage for eye exams and glasses or contacts. With Delta Dental, you can keep your smile and vision healthy at a price you can afford.

With the help of the EyeMed Insight network, DeltaVision members have lots of choices — be it an independent eye doctor, popular retailer or online option.

The Insight network has almost 700 eye care providers at more than 330 locations in Arkansas. This includes 257 indepedent provider locations and 79 retail locations including Walmart®, Sam's Club, Lenscrafters®, PearleVision® and TargetOptical®.

VISION PLANS

In-Network Vision Covered Benefits		
Vision Exam	Every 12 months	Covered in full after $10 copay
Frames	Every 24 months	$150 retail allowance
Lenses	Every 12 months	Standard single vision, bifocal, trifocal and lenticular covered in full after $15 copay
Contact Lenses (in lieu of lenses and frames)		
Contact Lens (elective)	Every 12 months	$150 which can be used toward the evaluation, fitting and follow-up care
Contact Lens (medically necessary)	Every 12 months	Covered in full with prior authorization
Laser Vision Correction	Once per lifetime	15% off retail price or 5% off promotional pricing

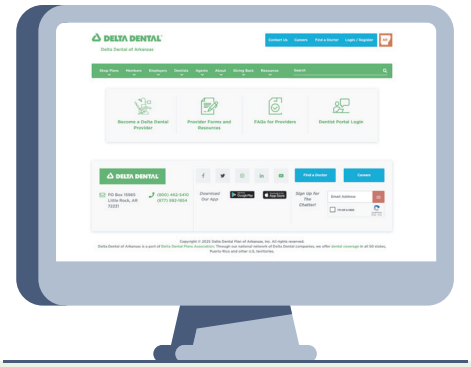
Dental & Vision Benefits Monthly Premiums			
Individual Only **$48.23**	Individual & Spouse **$96.21**	Individual & Child(ren) **$92.95**	Individual & Family **$153.39**

For more information about out-of-network benefits, please call (844) 487-6453.

Why Delta Dental?

Dental insurance is not a sideline of our business — it is the heart.

We are the state's largest and most experienced dental insurance company, and our expertise is why nearly 2 million members across the country trust their smiles to Delta Dental of Arkansas.



Easy access

We make it easy for you to access the information you need at any time. Through our website, you can:

- Locate a dentist
- Check claims status and history
- Review plan coverage
- Print ID cards,
- and more!

FREQUENTLY ASKED QUESTIONS

Who is eligible for coverage under a Delta Dental Individual and Family plan?

You must be an Arkansas resident and a State of Arkansas Retiree Program member to be eligible for coverage. Acceptance is guaranteed regardless of age, dental history or pre-existing conditions.

What are the age limitations for dependent children?

Dependent children can continue coverage until the end of the month in which they turn 26.

What services are NOT covered under this plan?

For a complete list of services not covered, please visit our website to view the Schedule of Benefits. General services that are not covered include:

- Tooth implants
- Tooth whitening
- Athletic mouth guards
- Braces and retainers
- Treatment for TMJ (temporomandibular joint disturbances)
- Services to correct cosmetic dentistry
- Dental care started prior to the date the patient became covered under this plan

DELTA DENTAL®

DeltaDentalAR.com

DELTA DENTAL®

MAIL TO: Arkansas Health First
1301 West 7th Street
Little Rock, AR 72201
FAX: (501) 663-1445
Email: service@arseba.com

REQUESTED EFFECTIVE DATE		
MONTH	DAY	YEAR
	1st	

Individual & Family Application | Plan number SOARR01

APPLICANT INFORMATION			
Name:	Date of Birth:	☐ Male ☐ Female	
Mailing Address:	City:	State:	ZIP:
Social Security #:	Home Number:		
Email:	Mobile Number:		

PLAN SELECTION (CHOOSE ONE)	TYPE OF COVERAGE (CHOOSE ONE)
☐ Dental ☐ Dental and Vision	☐ Individual ☐ Individual and Spouse ☐ Individual and Child(ren) ☐ Family

DEPENDENTS

	First Name	Last Name	Social Security #	Date of Birth	Sex
Spouse					
Child					
Child					
Child					

PREVIOUS COVERAGE

Will this replace existing dental coverage? ☐ YES ☐ NO

Previous Coverage Carrier: _____
Previous Coverage Start Date: _____ End Date: _____

If the coverage will replace a plan with another carrier, please submit a copy of the Certificate of Creditable Coverage and a list of covered benefits so we can determine if waiting periods for your Delta Dental plan can be waived. A Certificate of Creditable Coverage benefits can be obtained from your previous insurance carrier on your employer group health administrator.

HOUSEHOLD RESIDENTIAL INFORMATION

Do all proposed insureds reside in Arkansas? ☐ YES ☐ NO | If no, provide reason:

PAYMENT METHOD - BANK DRAFT OR CREDIT CARD ONLY (DO NOT SEND A LIVE CHECK)

Bank Draft: ☐ Monthly ☐ Annually
Bank Account: ☐ Checking ☐ Savings

Routing Number:_____
Account Number:_____

Include a voided check with application.

I authorize Delta Dental of Arkansas (DDAR) and the BANK* indicated above to debit my DDAR premium from my checking or savings account indicated above. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such a time and such a manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) day written notice of the BANK's termination of this agreement.

I understand that by revoking the Pre-Authorization Bank Draft Program after I have agreed to it, I will also be terminating my DDAR coverage, unless DDAR has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorization Bank Draft Program date.

_____ _____
Signature of Bank Account Holder Date

Monthly bank drafts are processed on the 27th of each month. *BANK also applies to Savings and Loan.

CREDIT CARD INFORMATION

Credit Card: ☐ Monthly ☐ Annually **Credit Card Type:** ☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number:_____ Expiration Date (MM/YYYY):_____

Credit Card Holder's Name: _____

_____ _____

Signature of Credit Card Holder Date

Your first premium payment will be processed when your application is submitted. Subsequent drafts are processed on the 27th of each month. (Example: February premium will be drafted on January 27th.)

CORRESPONDENCE

NOTICE: All correspondence regarding this plan will be sent electronically to the email address listed on the front of this application unless applicant requests to be contacted via mail.

☐ Opt OUT of electronic correspondence

POLICY EFFECTIVE DATE

The Delta Dental policy effective date is always the 1st of the month. Applications can be submitted through mail or online at www.deltadentalcoversmysmile.com/s/SOAR. This application must be received by Delta Dental of Arkansas by the 25th of the month prior to the effective date (example: received by January 25th to be effective February 1st). Applications received after the 25th of the month will be made effective on the 1st of the following month (example: received January 26th, will be effective March 1st).

AUTHORIZATION

I 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 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.

Applicant's Signature: _____ Date:_____

Signature of Parent/Legal Guardian: _____ Date:_____

(if policy is for a minor only)

City in which application was signed:_____, Arkansas

CERTIFICATION

I understand that I will not have benefits for basic and major restorative services (depending on my selected plan) during the first 6 months after the issue date, including for a disease or physical condition which I now have or have had in the past, unless I supply Delta Dental of Arkansas with certification of creditable coverage.

I certify that any 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 fine and confinement in prison. Statements made in this application are representations not warranties.

_____ _____

Applicant Signature Date

To be completed by sales representative ONLY if applicable

Agent's Name: _____ Agency's Name: Arkansas Health First

Agency NPN#: 19299106 Telephone Number: (888) 224-5233