

Mail to:
 Arkansas United Methodist
 Conference Benefits Office
 PO Box 2941
 Little Rock, Ar. 72203-2941
 Fax: 501-324-8043

CORESOURCE

A Trustmark Company

ENROLLMENT FORM

EMPLOYER	GROUP # ARMETOI
APPLICANT NAME (LAST, FIRST, M.I.)	SOCIAL SECURITY NUMBER

APPLICANT ADDRESS	STREET	CITY	STATE	ZIP
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POSITION	DEPT CODE	DATE OF BIRTH	SEX M F	MARITAL STATUS S M D W	EMPLOYMENT DATE
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I HEREBY APPLY FOR MEDICAL COVERAGE ON: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Employee and Child(ren) <input type="checkbox"/> Employee, and Family	I HEREBY APPLY FOR DENTAL COVERAGE ON: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Employee and Child(ren) <input type="checkbox"/> Employee, and Family
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1. BENEFICIARY N/A	LAST NAME, FIRST NAME(S)	RELATIONSHIP TO EMPLOYEE
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2. BENEFICIARY N/A	LAST NAME, FIRST NAME(S)	RELATIONSHIP TO EMPLOYEE
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COMPLETE THE FOLLOWING FOR ELIGIBLE DEPENDENTS

FULL NAME (LAST, FIRST, M.I.)	SOCIAL SECURITY NUMBER	D.O.B. MO./DAY/YR.	SEX	RELATIONSHIP TO EMPLOYEE	FULL TIME STUDENT?	OTHER COVERAGE?
				<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Step-Child <input type="checkbox"/> Other	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Step-Child <input type="checkbox"/> Other	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Step-Child <input type="checkbox"/> Other	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Step-Child <input type="checkbox"/> Other	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Step-Child <input type="checkbox"/> Other	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

IF CHILD IS OVER 19, HE/SHE IS A FULL TIME STUDENT AT:
 NAME OF COLLEGE _____
 ADDRESS OF COLLEGE _____ TELEPHONE NO. OF COLLEGE _____

DO ALL COVERED DEPENDENTS LIVE WITH EMPLOYEE? YES NO IF "NO," LIST DEPENDENTS AND EXPLAIN:

ARE ANY BENEFITS AVAILABLE FROM ANY OTHER GROUP HEALTH INSURANCE PLAN? (Circle YES or NO)	EMPLOYEE YES NO	SPOUSE YES NO	DEPENDENT CHILDREN YES NO
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REMARKS: If you have indicated "YES" to the Above, please provide the following information regarding the other coverage.

EMPLOYER OR GROUP NAME	GROUP NUMBER
EFFECTIVE DATE	ID NUMBER
NAME & ADDRESS OF INSURANCE COMPANY	TELEPHONE NUMBER

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION
 This form will authorize any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me and/or my family, or our health, to give CoreSource, a reinsurer, the Medical Information Bureau or any authorized organization, any such information. This information is used in claims administration and underwriting. A copy of this authorization shall be considered as effective and valid as the original within the year and date signed, unless revoked in writing at an earlier date. I certify that all information contained on this form is true and accurate. I will promptly notify my employer with any changes in the status of this information.

Date Signed _____ Employee Signature _____
 Date Signed _____ Spouse's Signature (if covered) _____

WAIVER OF COVERAGE: Medical Dental Life Dependent

This is to acknowledge that the available coverages have been explained to me by my employer. I have been given the opportunity to apply for the available coverages and have elected not to enroll myself and/or dependents, if any, for the coverage(s) checked above.

I am declining the available coverages because of other health insurance. I am declining the available coverages for other reasons.

Employee Signature _____ Date Signed _____

NOTICE: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

CHILD NAME & NUMBER