320 W. Capitol, Suite 500
P.O. Box 1151
Little Rock, AR 72203-1151

APPLICATION FOR REINSTATEMENT

_______________	_______________	_______________
Legal Name of Firm	**Group Number**	**Telephone**

Firm Address _______________ **City** _______ **State** _______ **Zip Code** _______ **County** _______

Firm's Executive Contact _______________ **Firm's Administrative Contact** _______________

Business Type (Please check appropriate box): ☐**Sole Proprietor** ☐**Corporation** ☐ **Government Entity**

Federal Tax I.D. Number______________________

Group Information:

Total Number of full time employees? ______________________________________
Total Number of eligible employees currently enrolled? _______________________
Number of full time employees not currently covered? ________________________
List the names of those not currently covered that have no other insurance coverage:

_________________________ _______________________________

_________________________ _______________________________

Employer contribution ______________% **Dependent contribution** _________%

IMPORTANT NOTE: If Employer Contribution is 100%, all eligible employees must be enrolled.

To the best of your knowledge and belief, are any employees or dependents now disabled, unable to or not at work, hospital confined, on leave of absence, handicapped, contemplating hospital confinement or otherwise incapacitated as of this date? (If yes, please list names and details on the following lines).

____
____
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I hereby certify that all of the information contained in this group enrollment application is correct to the best of my knowledge.

____________________________________ ____________________

Group Administrator **Date**

NOTE: To process your reinstatement request, we need the following: This completed application for reinstatement, a cashier's check in an amount sufficient to bring your account current, and a separate cashier's check in the amount of $350.00 for the nonrefundable reinstatement request processing charge.