



STATE OF ARKANSAS
Department of Finance
and Administration

EBD
Employee Benefits Division
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<http://www.ARBenefits.org>

Change Form
Status, Name and Address



1. Employee Information: (please print)					
Last Name		First Name		MI	<input type="checkbox"/> Married <input type="checkbox"/> Single
Home Address		City	State	Zip Code	
SSN#	Date of Birth:	Home #:	Work #:		
If you would like benefit information sent to you by email, please print your email address:					
Primary Care Physician:		PCP #	Current patient?		

2. Change in Dependent Status (complete this portion if making any changes in dependent status):					
LAST NAME		FIRST NAME		MI	GENDER
Social Security #		Date of Birth		<input type="checkbox"/> Add	<input type="checkbox"/> Delete
Primary Care Physician:		PCP #	Full time student?*		
LAST NAME		FIRST NAME		MI	GENDER
Social Security #		Date of Birth		<input type="checkbox"/> Add	<input type="checkbox"/> Delete
Primary Care Physician:		PCP #	Full time student?*		
LAST NAME		FIRST NAME		MI	GENDER
Social Security #		Date of Birth		<input type="checkbox"/> Add	<input type="checkbox"/> Delete
Primary Care Physician:		PCP #	Full time student?*		

* Please submit guardianship, court-ordered insurance responsibility or adoption papers on dependents that apply.

**For dependents 19 and over only. Please submit proof of student status.

3. Change In Coverage (complete this portion if making any of the following changes):	
Change in Status:	Reason for Change:
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Family <input type="checkbox"/> Cancel Coverage	<input type="checkbox"/> Birth - Date: _____ <input type="checkbox"/> Death - Date: _____ <input type="checkbox"/> Divorce - Date: _____ <input type="checkbox"/> Marriage* - Date: _____ <input type="checkbox"/> Other: _____
<input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent <input type="checkbox"/> Name <input type="checkbox"/> Address	

* Please attach Marriage License; Maiden Name if applicable

4. To Be Completed By Agency/School District:	
Agency/School District Name:	Agency/School District #:
Effective Date of Change:	Employee #:
Representative Signature:	Date:

Employee Signature: _____ **Date:** _____