



STATE OF ARKANSAS
**Department of Finance
 and Administration**

EBD
 Employee Benefits Division
 Post Office Box 15610
 Little Rock, AR 72231-5610

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 683-0230 www.ARBenefits.org

Refund Request Form - State Employees

Agency Name: _____ Agency #: _____

Insured Name: _____ Social Security #: _____

Address: _____ Health Plan: _____

_____ AASIS pay period: _____

Insurance Premium:

Amt. Deducted Per Pay Period \$ _____

Less Correct Premium Amt. --\$ _____

Amt. Over Deducted \$ _____ X _____ pay periods over deducted = \$ _____

Less FICA Withholding (7.65%) -\$ _____ *

Total Refund \$ _____

*W-2 Adjustments Form must be attached to refund request when FICA is deducted. EBD will electronically deposit the FICA withholding and FICA match for each agency.

Reason for Refund: _____

 Insurance Representative Signature

 Date

For EBD Office Use Only:

System ID: _____

Total Refund: _____

Date Received: _____

Less Misc. Charges: _____

Date Reviewed: _____

Total Adj. Refund: _____

Date Completed: _____

Memos: _____



STATE OF ARKANSAS
Department of Finance
and Administration

EBD
Employee Benefits Division
Post Office Box 15610
Little Rock, AR 72231-5610

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 683-0230 <http://www.ARBenefits.org>

W-2 Adjustment Form

Calendar Year

Employee Name

Personnel Number

Social Security #

Federal Taxable Wages

FICA Taxable Wages

FICA/MED Taxable Wages

State Taxable Wages

FICA Contributions

FICA/Med Contributions

Signature/Date/Telephone Number

Agency Name/Business Area