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) 683-0983 http://www.ARBenefits.org

Change Form
Status, Name and Address

1. Employee Information: (please print)					
Last Name	First Name			MI	❒ Married ❒ 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	❒Add	❒Delete
Primary Care Physician:	PCP #	Full time student?**	
LAST NAME	FIRST NAME	MI	GENDER
Social Security #	Date of Birth	❒Add	❒Delete
Primary Care Physician:	PCP #	Full time student?**	
LAST NAME	FIRST NAME	MI	GENDER
Social Security #	Date of Birth	❒Add	❒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:	
❒ Employee Only	❒ Add Dependent	❒ Birth	- Date: _____
❒ Employee & Spouse	❒ Delete Dependent	❒ Death	- Date: _____
❒ Employee & Children	❒ Name	❒ Divorce	- Date: _____
❒ Family	❒ Address	❒ Marriage*	- Date: _____
❒ Cancel Coverage		❒ Other: _____	

* 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:** _____