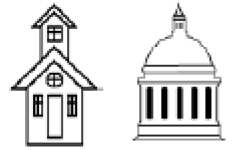
State of Arkansas

Department of Finance

and Administration

Employee Benefits Division

www.ARBenefits.org
This form must be returned to you
Heath Insurance Representative; not EBD



Change Form

Status, Name and Address

1. Employee Information:

Last Name ______ First Name ______ MI ______ ☐ Married ☐ Single

Home Address ______ City ______ State ______ Zip ______

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? ______

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**: ______________________

6000-f-2

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