State of Arkansas
CHANGE IN STATUS FORM

Social Security #		Dept./Agency		
Last Name (Please Print)	First Name			MI
Home Address Street	City		State	Zip
Work Phone ( )	Home Phone ( )	E-mail		

Please indicate the type of Change in Status incurred:

____________ Marriage
____________ Divorce
____________ Death (employee, spouse, or dependent)
____________ Birth of child
____________ Adoption of child
____________ Beginning or end of employment of spouse
____________ Ineligibility of dependent (due to age, marriage or loss of full-time student status)
____________ From full-time to part-time employment or vice versa (employee or spouse)
____________ Unpaid leave of absence (employee or spouse)
____________ Significant change in health coverage due to spouse's employment
____________ COVID-19

This is to certify that on___________________________ (date of event), I incurred the Change In Status checked above, and therefore wish to change my plan benefits as indicated below. I under-stand that the change requested must be consistent with the change status event and I have attached legal document of such change.*

Signature ____ Date ___________________________

**Examples of documentation include marriage, birth, or death certificate; divorce decrees; proof of change in spouse's employment; or adoption papers.*

CHANGE REQUESTED

This form is to be be used for changes to Medical Expense & Dependent Care Flexible Spending Accounts Only.

To make changes to your ARBenefits health insurance plan due to a qualifying event, please use the Active State & Public School Change Form and submit to EBD along with supporting documentation.

Mail completed form to:

EBD
P.O. BOX 15610
Little Rock, AR 72201
Fax: 1-501-683-0983

Customer Service: 1-877-815-1017x1

DEPENDENT CARE
Spending Account

☐ **Terminate Account**

☐ **Start Account:** I wish to contribute $ _____________ total during the remainder of this plan year, to be taken in equal installments from my remaining regular paychecks.

Change Existing Account:
☐ I wish to change from $ ________________ __________________ annual reduction to $ ______________________annual reduction amount to be taken in equal installments from my remaining regular paychecks.

MEDICAL EXPENSE
Spending Account

☐ **Terminate Account**

☐ **Start Account:** I wish to contribute $ _____________ total during the remainder of this plan year, to be taken in equal installments from my remaining regular paychecks.

Change Existing Account:
☐ I wish to change from $ ________________ annual reduction to $ _______ annual reduction amount to be taken in equal installments from my remaining regular paychecks.

©ConnectYourCare Card
Are you currently using the ConnectYourCare Card with your Medical Expense FSA or Limited Medical Expense FSA? yes ☐ no ☐

EMPLOYEES – Please complete and submit to EBD at the address or fax number above, along with any supporting documentation (i.e., birth certificates, marriage certificates, etc.). Forms that do not have any supporting documentation will not be processed.
HEALTH INSURANCE REPRESENTATIVES – Once you receive an approved form from EBD, make the deduction changes in AASIS.

To be completed by EBD
Date received:______________
Date copy sent to state agency: _____________________________

Change Approved

☐ Yes ☐ No

Other: _________________________________