2025 ARBenefits Public School Employee Retirement Packet

Employee Benefits Division · ARBenefits
PO Box 15610 · Little Rock, AR 72231
Phone: 877-815-1017 Fax: 501-682-1200

Revised: 4.21.2025


ARKANSAS DEPARTMENT OF
TRANSFORMATION AND SHARED SERVICES
AR

Eligibility

To be eligible for ARBenefits retiree coverage:

1. Employees hired before July 1, 2022, must be an active member of the ARBenefits plan on the last day of their employment; and begin drawing an annuity through their participating retirement system.

OR

2. Employees hired after July 1, 2022 – June 30, 2025, must have five (5) cumulative years enrolled on the ARBenefits plan; and begin drawing an annuity through their participating retirement system.
    - Effective July 1, 2025, employees hired after July 1, 2022 must have five (5) cumulative years enrolled on the ARBenefits plan before retirement; and are vested members one of the participating retirement systems (see below), and are retired as determined by one or more of those retirement systems.

Former employees are held to the retirement eligibility rules in place when they left employment.

They have thirty (30) days to enroll in retiree coverage after meeting above criteria 1 - 2 listed above.

If you gain other group coverage upon ending your employment with the Public Schools due to retirement, you must enroll within thirty (30) days of losing that coverage.

Retirements Systems

- The Arkansas Public Employees' Retirement System,
    - including the members of the legislative division and the contract personnel of the Arkansas National Guard;
- The Arkansas Teacher Retirement System;
- The Arkansas State Highway Employees' Retirement System;
- The Arkansas Judicial Retirement System; or
- An alternate retirement plan as defined in § 24-7-202.

Non-Medicare Retirees

Non-Medicare Retirees

If you are not yet eligible for Medicare, you can still remain on ARBenefits health insurance.

You must notify Employee Benefits Division (EBD) of your retirement from the state so EBD can terminate your active coverage. You can elect to continue working or become a dependent on your spouse's coverage. Once you lose that coverage you will have thirty (30) days to enroll in an ARBenefits retirement plan.

Pre-65 Non-Medicare Retiree Plan Options

Non-Medicare retirees can enroll in either the Premium, Classic, or Basic Plan. These are the same plans you had as an active member.

	Premium	Classic	Basic
Individual Deductible	$750	$1,750	$4,000
Family Deductible	$1,500	$3,300/$3,500	$8,000
Individual Out-of-Pocket	Medical: $3,250 Pharmacy: $3,100	$6,450	$6,450
Family Out-of-Pocket	Medical: $6,500 Pharmacy: $6,200	$9,675	$12,900
Doctor's Office Visit	$25 copay	20% after deductible	20% after deductible
Specialist Office Visit	$50 copay	20% after deductible	20% after deductible
Urgent Care Visit	$100 copay	20% after deductible	20% after deductible
In-Patient Services	20% after deductible	20% after deductible	20% after deductible
Out-Patient Services	20% after deductible	20% after deductible	20% after deductible
Wellness Exams/Preventative Care	$0	$0	$0

Medicare Retirees

Medicare eligible retirees can select from the two Medicare plans with ARBenefits starting the first month of Medicare eligibility.

Ninety (90) days prior to turning sixty-five (65), you will receive a Pre-65 Election Request Letter. You must submit your completed Retiree Election Form and all other required documentation to EBD forty-five (45) calendar days from the date of the Election Request letter.

To enroll in Medicare Part A & Part B and learn more, you can:

- Visit https://www.medicare.gov
- Call 1-800-MEDICARE (1-800-633-4227)

You will need to provide EBD with a copy of your Medicare card showing the start date(s) of your Medicare Part A & Part B.

Medicare Retiree Plan Options

Medicare-eligible retirees can enroll in either the UnitedHealthcare (UHC) Group Medicare Advantage with Prescription Drugs PPO Plan (MAPD) or the Health Advantage (HA) Medicare Primary Plan.

Option 1 - Provided by UnitedHealthcare

The ARBenefits UHC MAPD plan differs from other Medicare plans you might see advertised and is designed specifically for our state and public school Medicare-eligible retirees. The ARBenefits UHC MAPD plan includes the benefits of Medicare Part A, B, and D (you cannot enroll in a separate Part D plan under this option). This Plan provides you Pharmacy coverage and you do not need to enroll in an additional Medicare Part D

Additional benefits include:

- The ability to see any provider (in or out of network) as long as they accept Medicare
- Free gym memberships
- Enhanced hearing and vision benefits
- Dental coverage
- Drug coverage with drug list managed by UHC

For more information:

- Call UnitedHealthcare: 1-844-488-3953
- Visit: www.transform.ar.gov/employee-benefits/retirees/medicare-advantage

IMPORTANT: You can only be enrolled in ONE (1) Medicare Advantage Plan or ONE (1) Medicare Prescription Drug Plan (Medicare Part D) at a time. If you enroll in ANY other Medicare Advantage or Medicare Part D plan, you will AUTOMATICALLY be disenrolled from the ARBenefits UHC MAPD Group Plan and lose the benefits you have selected.

Option 2 - Provided by Health Advantage

The Health Advantage Medicare Primary Plan coordinates with your Medicare Part A & B benefits.

Public School Employee Medicare retirees **do not** have prescription drug coverage under the ARBenefits Primary Medicare Plan with Health Advantage. If you want prescription drug coverage you will need to enroll in a separate Part D plan.

EBD will pay your physician claims like you have Medicare Part B coverage, even if you choose not to participate in Part B. See below.

For more information you can contact EBD at: 1-877-815-1017.

Remember: If you cancel your ARBenefits retirement coverage to leave the plan for any reason OTHER than gaining employment with an Arkansas state agency or an Arkansas public school district, that cancellation is FINAL and you cannot return to the ARBenefits plan.

Coordination of Benefits with Medicare

The Health Advantage Medicare Primary Plan will coordinate as if Medicare Part A and Part B are both in force at the time of service. If you do not have Medicare Part B, the Plan will pay as though you have Medicare Part B, and you will be responsible for any incurred claims.

Medicare Part A (hospital insurance) does not usually require recipients to pay a monthly premium. Medicare Part A includes coverage for:

- Inpatient hospital stays
- Hospice care
- Skilled nursing facility care
- Some home health care

Medicare Part B (physician insurance) is optional and usually requires a monthly premium. Medicare Part B includes coverage for:

- Certain doctor services
- Outpatient care/Medical supplies
- Preventative services

Examples of patient responsibility/liability with and without Medicare Part B:

Your payment with Medicare Part B
Office visit: $150
Medicare approved: $110
Medicare payment: $88
Medicare write-off: $40
ARBenefits payment: $22
Member amount due: $0

Your payment without Medicare Part B
Office visit: $150
Medicare approved: $110
Medicare payment: $0
Medicare write-off: $40
ARBenefits payment: $22
Member amount due: $88

Medicare Part C (Medicare Advantage) is another Medicare health plan choice that provides all of your Part A and Part B coverage and many also provide Part D. Medicare pays a fixed amount to companies offering Medicare Advantage Plans and they must follow the rules set by Medicare.

Medicare Part D is a prescription drug plan that can be provided under a Part C plan or sold by private insurance companies.

Part D coverage is included in the UHC MAPD plan and if you sign up for a Part D plan while on the MAPD plan you will be kicked off and not permitted to return to any ARBenefits plan.

Public School Retirees **do not** have drug coverage included with the Health Advantage Primary Medicare Plan.

Retiree Open Enrollment

You are only allowed to change plans during the Retiree Open Enrollment Period. You are not permitted to add any other dependents as part of Open Enrollment.

If you do not wish to make any changes to your plan during Open Enrollment, then no update is needed from you.

Any changes made during Open Enrollment with take effect January 1 of the following year.

Life, Dental, and Vision Care

Life Insurance

If you want to continue any Colonial Life coverage in retirement you must submit the Colonial Life Election Form. If Colonial Life does not receive your election form within thirty-one (31) days after your retirement date, then you cannot regain that coverage later.

The Arkansas State Employee Benefit Advisors (ARSEBA) has more options for life insurance coverage for retirees. Contact them to discuss those options at 501-224-5234.

Dental and Vision

Dental and vision are also provided through ARSEBA. For more information or to enroll, visit www.mysmilecoverage.com/SOAR.

For retirees on the UHC MAPD Plan, dental and vision coverage includes an annual eye exam, a $150 annual allowance for glasses or contacts (not related to cataract surgery), and limited preventative dental care (review plan for allowances). UHC MAPD Plan members are allowed to enroll in additional dental and vision coverage.

Completing the Retiree Election Form

Eligible retirees can begin submitting the Retiree Election Form thirty (30) days prior to their eligibility date and have until thirty (30) days AFTER the eligibility date to enroll in coverage.

You must submit a Retiree Election Form to EBD in order to be enrolled in retiree coverage.

These are the individual boxes you will see on the form and what EBD needs for each of them:
Event date: Your last day of employment.
Date annuity begins: When you start drawing your retirement check.
Action requested: Enroll in the plan.
Retirement system: Mark the correct retirement system. Public School employees mark ATRS.
Benefit option: Choose which plan you wish to enroll.

- If you or your covered spouse is Medicare eligible, you/your spouse can choose from the UnitedHealthcare MAPD or the Health Advantage Primary Plan. Medicare eligibility is determined by age - 65 or older - or by disability. You must include a copy of the Medicare card as soon as possible.
- If you and your covered spouse are NOT Medicare eligible, you can choose the Health Advantage Premium, Classic, or Basic Plan.

Coverage Level: Retiree only, Retiree and spouse, Retiree and child(ren), or Retiree and Family
Dependents: Only dependents on your active health plan can be added as dependents on your retirement plan.

Sign and date your form and enter your email address.

Once all eligibility requirements are met and the requested documentation is received, the effective date of coverage is the first day of the month following the date EBD receives your completed application for your retirement health insurance.

Example: If EBD receives completed forms on 2/15, then coverage will begin on 3/1.

Arkansas Law allows a retiree a one-time option to enroll in the State and Public-School Retirement Health Plan. Enrollment is either at the time of eligibility or delayed enrollment due to current coverage on an employer-sponsored group health plan with a qualifying event of involuntary loss of coverage. Once you leave the ARBenefits retirement plan, you will no longer be eligible for participation in the plan. This decision is FINAL.

Once you become eligible for Medicare, you must provide EBD with a copy of your Medicare card, indicating the start dates of both Medicare Part A and Part B coverage.

EBD may also request updated documents to maintain eligibility for our records.

This packet contains additional forms that may require your attention, including:

Retiree Election Form: The general form that all retirees must complete to select coverage.
Authorization to Release Information: Allows authorization for another individual to access your medical information. If you have a Power of Attorney (POA) on file, you do not need this form.
ARBenefits Spousal Affidavit: This must be completed to add your spouse to the plan.
Colonial Life Retiree Deduction Authorization: If you want to continue with Colonial Life coverage with the state, you must complete this form.
Dental and Vision Form: These must be completed to add retirement dental and/or vision coverage.
Bank Draft Authorization Form: If your annuity is not enough to cover your premium or if you would like your premiums drafted from your bank account, you will need to submit this form. If you choose to have your premium drafted from your bank account, you must include a second, voided check along with the Bank Draft Authorization Form.

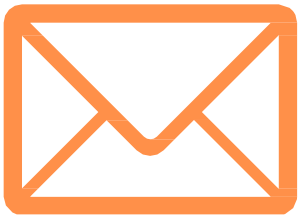
Payment

EBD requires a check payment as the initial payment for retirement insurance.

If you choose to have your premiums taken from your annuity, it will begin the second month of coverage.

You can choose to have premium payments come out of your bank account or your annuity at any time.

Contact EBD with any additional questions



P.O. Box 15610
Little Rock, AR 72231

877-815-1017

Ask.EBD@arkansas.gov

Other Contact Information

Phone: 501-682-1517
Toll Free: 800-666-2877
Website: www.artrs.gov

Phone: 501-224-5234
Fax: 501-663-1445
Toll Free: 800-682-7377
Email: service@arseba.com
Website: www.apers.org

Phone: 501-683-3151
Toll Free: 800-525-4368
Website: www.coloniallife.com

Phone: 501-301-9900
Website: www.voya.com

Phone: 800-633-4227
Website: www.Medicare.gov

Phone: 800-772-1213
Website: www.SSA.gov

RATES


ARKANSAS DEPARTMENT OF
TRANSFORMATION AND SHARED SERVICES
AR

AR BENEFITS

PUBLIC SCHOOL NON-MEDICARE RETIREE MONTHLY PREMIUMS

RATES EFFECTIVE JANUARY 1, 2025 – DECEMBER 31, 2025

PLAN	BASE MONTHLY PREMIUM	STATE & PLAN CONTRIBUTION	TOTAL MONTHLY RETIREE COST
PREMIUM			
RETIREE ONLY	$900.60	$371.64	$528.96
RETIREE & NON-MEDICARE SPOUSE	$1,801.20	$554.58	$1,246.62
RETIREE & CHILD(REN)	$1,240.82	$269.02	$971.80
RETIREE & NON-MEDICARE SPOUSE & CHILD(REN)	$2,141.42	$490.50	$1,650.92
RETIREE & MEDICARE PRIMARY SPOUSE	$1,139.24	$442.46	$696.78
RETIREE & MEDICARE PRIMARY SPOUSE & CHILD(REN)	$1,479.46	$339.82	$1,139.64
RETIREE & MAPD PRIMARY SPOUSE	$1,040.91	$497.91	$543.00
RETIREE & MAPD PRIMARY SPOUSE & CHILD(REN)	$1,381.13	$394.77	$986.36
CLASSIC			
RETIREE ONLY	$782.96	$530.78	$252.18
RETIREE & SPOUSE	$1,565.91	$966.37	$599.54
RETIREE & CHILD(REN)	$1,078.74	$617.96	$460.78
RETIREE & FAMILY	$1,861.69	$1,101.75	$759.94
BASIC			
RETIREE ONLY	$691.04	$557.50	$133.54
RETIREE & SPOUSE	$1,382.07	$1,047.67	$334.40
RETIREE & CHILD(REN)	$952.09	$690.41	$261.68
RETIREE & FAMILY	$1,643.14	$1,233.58	$409.56
The Basic Plan meets the minimum essential coverage required under A.C.A.			

State Contribution is funded by legislation.

Plan Contribution is funded by PSE Trust Fund as Claims Reserve Allocation.

AR BENEFITS

PUBLIC SCHOOL MEDICARE UNITEDHEALTHCARE (UHC) MAPD GROUP RETIREE MONTHLY PREMIUMS (MEDICAL & PHARMACY)

RATES EFFECTIVE JANUARY 1, 2025 – DECEMBER 31, 2025

MEDICARE ELIGIBLE	BASE MONTHLY PREMIUM	STATE & PLAN CONTRIBUTION	TOTAL MONTHLY RETIREE COST
MAPD RETIREE ONLY	$140.31	$126.28	$14.03
MAPD RETIREE & NON-MEDICARE SPOUSE	$1,040.91	$366.63	$674.28
MAPD RETIREE & CHILD(REN)	$480.53	$108.31	$372.22
MAPD RETIREE & MAPD CHILD	$280.62	$252.56	$28.06
MAPD RETIREE & NON-MEDICARE SPOUSE & CHILD(REN)	$1,381.13	$274.07	$1,107.06
MAPD RETIREE & NON-MEDICARE SPOUSE & MAPD CHILD	$1,181.22	$592.91	$688.31
MAPD RETIREE & MAPD PRIMARY SPOUSE	$280.62	$252.56	$28.06
MAPD RETIREE & MAPD PRIMARY SPOUSE & CHILD(REN)	$620.84	$180.00	$440.84
MAPD RETIREE & MAPD SPOUSE & MAPD CHILD	$420.93	$378.84	$42.09

Subsidy authorized by Act 1075 of 2011.

Plan Contribution is funded by PSE Trust Fund as Claims Reserve Allocation.

AR BENEFITS

PUBLIC SCHOOL MEDICARE PRIMARY RETIREE MONTHLY PREMIUMS

RATES EFFECTIVE JANUARY 1, 2025 – DECEMBER 31, 2025

MEDICARE ELIGIBLE	BASE MONTHLY PREMIUM	STATE & PLAN CONTRIBUTION	TOTAL MONTHLY RETIREE COST
RETIREE ONLY	$238.64	$116.66	$121.98
RETIREE & NON-MEDICARE SPOUSE	$1,139.24	$374.06	$765.18
RETIREE & CHILD(REN)	$578.86	$58.24	$520.62
RETIREE & NON-MEDICARE SPOUSE & CHILD(REN)	$1,479.46	$224.98	$1,254.48
RETIREE & MEDICARE PRIMARY SPOUSE	$477.28	$179.18	$298.10
RETIREE & MEDICARE PRIMARY SPOUSE & CHILD(REN)	$817.50	$80.44	$737.06

Subsidy authorized by Act 1075 of 2011.

Plan Contribution is funded by PSE Trust Fund as Claims Reserve Allocation.

FORMS


ARKANSAS DEPARTMENT OF
TRANSFORMATION AND SHARED SERVICES
AR

ARBENEFITS

State & Public-School Retirement Election Form

Employee Information

Legal First Name	MI	Legal Last Name	Date of Birth	Gender ☐M☐F	Social Security Number

Mailing Address	City	State	Zip Code

Physical Address

Event	Event Date	Date Annuity Begins	Home/Cell Number

Coverage

Type of Action

- ☐ Enroll in the Plan
- ☐ Enroll as a Surviving Spouse
- ☐ Add/Drop Dependents
- ☐ Open Enrollment
- ☐ Cancel Coverage

Choose Retirement System

- ☐ APERS (State) 998
- ☐ APERS (School) 059002
- ☐ APERS Judicial 021
- ☐ Highway Dept. 091
- ☐ ATRS (State) 999
- ☐ ATRS (School) 059001
- ☐ VALIC/TIFF - Alternate Retirement (Bank Draft)

Payment Method

Please complete Bank Draft Authorization Form

- ☐ Annuity
- ☐ Checking
- ☐ Savings

Pre-65 Plan

- ☐ Premium ☐ Basic
- ☐ Classic

Post-65 Plan

- ☐ United HealthCare MAPD
- ☐ Health Advantage Primary

Choose Coverage Level

- ☐ Employee Only
- ☐ Employee & Child(ren)
- ☐ Employee & Spouse
- ☐ Employee & Family

Medicare

OUR PLANS REQUIRE MEDICARE-ELIGIBLE RETIREES TO BE ENROLLED IN BOTH MEDICARE PART A & B.

Add/Drop Dependents

Please check the correct column to ADD a dependent to the plan or DROP a dependent currently covered. Proof of a dependent's eligibility must be submitted with this application for all dependents. To complete the RELATIONSHIP column, use the number that describes the dependent(s). Spouse - 1, Child - 2, Permanent Legal Guardian - 3

ADD	DROP	LEGAL NAME (FIRST, MI, LAST)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MALE	FEMALE	RELATIONSHIP
☐	☐				☐	☐	
☐	☐				☐	☐	
☐	☐				☐	☐	

Subscriber Certification

I authorize deductions of the required contributions (if applicable). I understand that my elections can only be changed during the next open enrollment period or if I have a qualifying event as defined in the ARBenefits Summary Plan Description. I understand I must request such changes within 30 days of the qualifying event. On behalf of myself and anyone enrolled on or added to this form, I authorize any health care professional or entity to give the health plan/insurer or any of their designees, any and all records or information pertaining to medical history or services rendered to the heath plan/insurer, for any administrative purpose, including evaluation of an application or claim. I also authorize on behalf of health plan/insurer the use of a Social Security Number for the purpose of identification. A photocopy of this authorization will be as valid as the original. Please note that falsifying documents, misrepresenting dependent status or using other fraudulent actions to gain coverage may be criminal acts and can lead to permanent termination of coverage. I understand by signing the election form, it means I have read and agree with the attached instruction page and understand the options I chose on the election form.

Employee Signature	Date	Email Address

SUBMISSION TO EBD IS FINAL

Department of Transformation and Shared Services • Employee Benefits Division
P.O. Box 15610 • Little Rock, AR 72231-5610 • Fax: 501-682-1200

Instructions

ALL PORTIONS OF THE ELECTION FORM MUST BE COMPLETED OR IT WILL BE SENT BACK FOR COMPLETION PRIOR TO PROCESSING.

Currently United HealthCare is the provider for the Group Medicare Advantage Plan (MAPD) plan and Health Advantage is the provider for the Medicare Primary Premium Plan. Each Medicare eligible member is required to maintain Medicare Part A & B coverage. A copy of the Medicare card is required for any subscriber and/or spouse/dependent.

ARBenefits Medicare Primary Premium Plan for retirees will coordinate as if Medicare Part A & B are both in force at the time of service. If the member does not have Part B, the plan will pay as though the member does have Part B coverage. The member will have full financial responsibility for incurred claims.

Public School Retirees who choose the Medicare Primary Premium Plan will NOT have pharmacy benefits through this plan. You will be required to obtain Medicare Part D for your pharmacy needs.

If you choose the UnitedHealthCare MAPD Plan and enroll in a separate Medicare plan outside of ARBenefits, you will automatically be canceled from ARBenefits coverage. If you have questions about your coverage, call ARBenefits before making your decision.

The Bank Draft Authorization Form, with VOIDED check attached, is required if your retirement annuity is not able to cover the full cost of your premiums. WE CANNOT PROCESS WITHOUT A VOIDED CHECK.

Your premiums are post-tax.

IF YOU CANCEL YOUR RETIREMENT INSURANCE OTHER THAN BY GAINING EMPLOYMENT WITH A STATE AGENCY OR PUBLIC SCHOOL, YOU WILL NOT BE ABLE TO COME BACK TO THE PLAN AND THE DECISION IS FINAL.

Completion of this form does not guarantee coverage on the retirement plan as certain conditions must be met in order to be enrolled on to either ARBenefits Retirement Plans.

RECIPROCITY SERVICE

- A retiree who is fully vested as a state employee AND fully vested as a public school employee (a participating member under both APERS and ATRS and drawing a retirement annuity from each may choose to enroll in with the ASE or PSE retirement health plan.
- A retiree who is not fully vested under either system, but has enough time between the two systems to be eligible for reciprocity service will be enrolled in the retiree health plan of the system with the most service.

VESTING

- State and Public School retirees changed from a ten (10) year vesting to a five (5) year vesting period effective 7/1/1997.
- Retirees with service prior to 7/1/1997 are still held to the ten (10) year vesting period.
- Non-teaching school retirees that are paid under Arkansas Public Employees Retirement System (APERS) have school rates.
- Most college and county employed retirees are NOT eligible under the State & Public School Retirement Health Insurance. Reciprocity services from these agencies do not make a retiree eligible for the health insurance.

Proof of dependent eligibility is required. Examples of required documentation: birth certificates, marriage licenses, court documents, and a Certificate of Credible Coverage (COCC) for loss of coverage.

If adding dependent as a permanent legal guardian you must include court documents and they will be subject to annual review.

You can also submit documents online through the ARBenefits Member Portal at www.myarbenefits.org/portal.

For assistance, contact ARBenefits at 1-877-815-1017 Monday - Friday, from 8:00AM - 4:30PM CST or email us at Ask.EBD@arkansas.gov.

Learn more about plans, costs, and network providers at www.transform.ar.gov/employee-benefits/retirees/

Coverage is effective the 1st of the month and termed at the end of the month following date of receipt and based on eligibility rules.

MAIL OR FAX FORM AND ACCOMPANYING DOCUMENTS TO:

Department of Transformation and Shared Services - Employee Benefits Division
PO Box 15610, Little Rock, AR 72231-5610 - FAX: 501-682-1200

SUBMISSION TO EBD IS FINAL

BANK DRAFT AUTHORIZATION

I hereby authorize the Department of Transformation and Shared Services - Employee Benefits Division to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debits in error to our bank account indicated at the financial institution listed below, hereinafter called 'Depository', to debit and/or credit the same such account.

First month Retirement and COBRA payments MUST BE MADE BY CHECK OR MONEY ORDER. If first payment is not included, the bank draft will not be setup nor will enrollment be completed.

All COBRA NSF drafts must be paid by the end of the month to avoid termination of coverage.

Select One:

☐ Retirement Effective Date: _____ ☐ COBRA Effective Date: _____

☐ Annuity

☐ Bank Draft

Bank Name: _____

Routing #: _____

Account #: _____

Type of Account	**Date of Draft**
☐ Checking ☐ Savings	☐ 5th ☐ 7th ☐ 15th ☐ 20th ☐ 28th *Not available for COBRA

This authorization shall remain in effect unless the Employee Benefits Division has received written notification from me (us) of its termination in such time and in such manner as to afford the Employee Benefits Division and Depository a reasonable opportunity to act on it.

Authorized Signer on Account: _____
(Please print name clearly)

Authorized Signer Signature: _____
(Authorized Signer) (Date)

Member ID #: _____ Last 4 SSN: _____

Per Arkansas Code Ann. §5-37-301, a $25.00 Return Item Charge fee plus a $2.00 service fee for bank drafts will be assessed per item returned not paid by the bank.

*** Please enclose the first month's payment and MUST have original check or Money Order. No copies or deposit slips can NOT be used.***

MAIL OR FAX FORM AND ACCOMPANYING DOCUMENTS TO:
Department of Transformation and Shared Services - Employee Benefits Division
PO Box 15610, Little Rock, AR 72231-5610 - FAX: 501-682-1200

Affidavit of Spousal Healthcare Coverage

Employee Name		Employee SSN	
Spouse Name		Spouse SSN	

To be completed by employee electing to enroll a spouse or when dropping a spouse due to gaining employer group coverage.

Pursuant to Arkansas Code Ann. §21-5-407(4), any spouse who is offered coverage for Medical Benefits under any other employer-sponsored health plan is NOT eligible to be covered under the ARBenefits Plan.

1. Is your spouse currently employed?

   ☐ Yes (If yes, please proceed to question #2)

   ☐ No (If no, sign and return this form along with your election form and a copy of your marriage license)

2. Is your spouse currently employed by an Arkansas state agency or public school district?

   ☐ Yes (If yes, sign and return this form along with your election form and a copy of your marriage license)

   ☐ No (If no, proceed to question #3)

3. Is your spouse eligible for his/her employer-sponsored group health plan?

   ☐ Yes

   ☐ No (Letter from employer explaining why they are not eligible is required. Spouse will not be added if this is not provided.)

   ☐ My Spouse is self-employed, provide company name: _____

For any questions or concerns, contact EBD at 1-877-815-1017 or email Ask.EBD@arkansas.gov

By signing this affidavit I certify that the information provided above is accurate. I understand that any misrepresentations in the information I provided above will permit the ARBenefits Plan to terminate my coverage. If applicable, I authorize the release of the information noted above and agree to its use in the application process for ARBenefits Plan coverage.

Employee signature: _____ Date: _____

Spouse signature: _____ Date: _____

MAIL OR FAX FORM AND ACCOMPANYING DOCUMENTS TO:
Department of Transformation and Shared Services - Employee Benefits Division
PO Box 15610, Little Rock, AR 72231-5610 - FAX: 501-683-0983

AR BENEFITS Authorization to Release Information

This form is used to release your protected health infomation as required by federal and state privacy laws. Your authorization allows the Employee Benefits Division (EBD) to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to EBD or filling out the Authorization to Revoke Release of Health Information form. Revoking this authorization will not effect any action taken prior to receipt of your written request.

Member Information (individual whose information will be released)

Name: _____ Member ID #: _____

Home Number: _____ Cell Number: _____ Birth date: _____

Address: _____ City: _____ State: _____ Zip: _____

I authorize EBD to release my protected health information as described below

Recipient (Person or Organization that will receive your information)

Person's Name or Organization: _____

Address: _____ Home Number: _____

Person's Name or Organization: _____

Address: _____ Home Number: _____

Description of the Information to be Released

☐ Entire Health Record

☐ Other, please describe _____

This authorization will expire (Check ONLY ONE Box)

☐ When I revoke this authorization

☐ Upon the following date, event, or condition _____

If I fail to select an option above, this authorization will expire in twelve (12) months from the date of this signing.

I understand that this authorization to release information is voluntary and is not a condition of enrollment in the ARBenefits Health Plan, eligibility for benefits, or payment of claims. I also understnad that once the information is disclosed pursuant to this authorization, it may be disclosed by the recipient and the information may not be protected by federal privacy regulations. I understand that the information in my health record may include information relating to sexually transmitted diseases, behavioral or mental health services, and treatment fo alcohol and drug abuse.

By signing below, I authorize the release of my protected health information as described above.

_____ _____

Signature of Member or Legal Representative Date

_____

Printed Name of Member or Legal Representative

MAIL OR FAX FORM AND ACCOMPANYING DOCUMENTS TO:

Department of Transformation and Shared Services - Employee Benefits Division

ATTN: Eligibility Department - PO Box 15610, Little Rock, AR 72231-5610 - FAX: 501-683-0983