AR BENEFITS

Active State & Public-School Qualifying Event Change Form

Employee Information

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

Agency/District	Group Number	Preferred Phone Number ☐Cell ☐Home ☐Work

Mailing Address	City	State	Zip Code

Physical Address	City	State	Zip Code

Changes to Coverage

Type of Action

- ☐ Add Dependent
- ☐ Drop Dependent
- ☐ Cancel Coverage

Reason for this Action

- ☐ Newborn
- ☐ Adoption
- ☐ Marriage
- ☐ Divorce
- ☐ Death
- ☐ Gain of Group Coverage
- ☐ Loss of Group Coverage
- ☐ Name Change

Post Tax Withholdings Change

- ☐ Add Post Tax
- ☐ Remove Post Tax

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. Submit supporting documents with this enrollment form to avoid processing delays. Check your ARBenefits Member Portal for additional information.

ADD	DROP	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 60 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 change form.

Employee Signature	Date	Email Address

SUBMISSION TO EBD IS FINAL

Department of Shared Administrative Services • Employee Benefits Division
P.O. Box 15610 • Little Rock, AR 72231-5610 • Fax: 501-683-0983

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

Instructions

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

This form is for use with Qualifying Events (QEs) **ONLY**. Do NOT use this form for Open Enrollment.

Review your current benefits, the available plans, and options. Then select the benefit options most suited to your personal needs.

Social Security Numbers are required for enrollment. Exception: A newborn's Social Security Number will be accepted after enrollment but must be sent in once it is received within 6 months.

You must drop all of your ineligible dependents. When your dependents no longer meet eligibility requirements, their coverage ends the last day of the month they became ineligible. You may be responsible for any cost for services received by the dependent(s) while your dependent(s) was incorrectly listed as eligible.

Members may make changes to their plan if they experience a qualifying status change, but they may not elect a different plan.

If you experience a qualifying event that allows you to cancel your health insurance, you can only enroll again during the next annual open enrollment period or if you have a qualifying status change event. Qualifying status change events include those listed on this form and may require you provide proof you have gained or lost group health care coverage.

You should receive plan information and ID cards in a timely manner from the Employee Benefits Division (EBD). If you do not, call EBD at 1-877-815-1017.

Your elections will remain in effect for the remainder of the calendar year unless you experience another qualifying status change event, as defined by the ARBenefits Summary Plan Description.

Your coverage will begin the first of the month following date of EBD receiving all applications and documentation. Note: The qualifying date is NOT the date of eligibility. Exception: Newborns will begin coverage the first of the month in which they are born.

Pre-tax premiums increase your take-home pay because your insurance premiums will be deducted from your salary before taxes are calculated. You will automatically be in a pre-tax status unless you select the post-tax option on this form and/or notify your payroll clerk.

Members who turn age 65 or become eligible for Medicare must send in a copy of their Medicare card (Part A & B) to EBD.
Supporting documentation is required for proof of dependent eligibility. For changes made due to a qualifying event, documented proof of a qualifying event is also required. More information available in the ARBenefits Summary Plan Description.

Adding a spouse:
* Copy of Marriage License
* Completed ARBenefits Spousal Affidavit

Adding a dependent child:
* Newborns - Birth Certificate or hospital birth announcement that includes parents' names and date of birth of the child
* Child - Copy of child's Birth Certificate OR a birth announcement up to 6 months of age
* Step-child - Copy of Marriage License to the step-child's parent and a copy of the child's Birth Certificate
* Adoption - Finalized court records (with judge's signature and seal)
* Permanent Legal Guardianship - Court order stating permanent guardianship (subject to annual review)

Loss of other Group Coverage:
* Certificate of Credible Coverage (COCC)
* Birth Certificates if adding children
* Marriage License and spousal affidavit if adding spouse

Completed change forms can be submitted to EBD by fax, mail, or via the ARBenefits Member Portal at www.myarbenefits.org

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 sas.arkansas.gov/employee-benefits/

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