



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:

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

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 understand 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 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 TSS EBD along with supporting documentation.

Mail completed form to:

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

**Customer Service: 1-877-815-1017
(press 1, then press 2)**

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 TSS 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 TSS EBD, make the deduction changes in AASIS.

To be completed by TSS EBD

Date received: _____

Date copy sent to state agency: _____

Change Approved

Yes No

Other: _____