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 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: _____