State of Arkansas
Department of Transformation and Shared Services

EBD
Employee Benefits Division
Post Office Box 15610
Little Rock, AR 72231-5610

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 683-0230 www.ARBenefits.org

Refund Request Form - State Employees

Agency Name: _____ Agency #: _____

Insured Name: _____ Social Security #: _____

Address: _____ Health Plan: _____

_____ AASIS Pay Period: _____

Insurance Premium:

Amt. Deducted Per Pay Period $ _____

Less Correct Premium Amt. - $ _____

Amt. Over Deducted $ _____ X _____ pay periods over deducted = $ _____

____ Less FICA Witholding (7.65%) - $ _____ *

Total Refund - $ _____

*W-2 Adjustments Form must be attached to refund request when FICA is deducted. EBD will electronically deposit the FICA withholding and FICA match for each agency.

Reason for Refund: _____

_____

_____ _____

Insurance Representative Signature Date

For EBD Office Use Only:

System ID: _____ Total Refund: _____

Date Received: _____ Less Misc. Charges: _____

Date Reviewed: _____ Total Adj. Refund: _____

Date Completed: _____

Memos: _____

_____

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W-2 Adjustment Form

Calendar Year: _____

Employee Name: _____

Personnel Number: _____ Social Security #: _____

Federal Taxable Wages: _____ FICA Taxable Wages: _____

FICA/MED Taxable Wages: _____ State Taxable Wages: _____

FICA Contributions: _____ FICA/MED Contributions: _____

_____

Signature / Date / Telephone Number

_____

Agency Name / Business Area