



2401 N. Lincoln Blvd., Oklahoma City, OK 73105 – Phone: 405-522-5528 or 800-219-8115

<p align="center"><b>COORDINATOR USE ONLY (must complete)</b></p> <p align="center">Event date _____</p> <p align="center">Requested effective date _____/01/_____</p> <p>This effective date will be the first of the month following the notice date unless the change is a birth or adoption. The event date and the effective date cannot be the same (except in the case of birth or adoption).</p>	<p align="center"><b>BENEFITS OFFICE USE ONLY</b></p> <div style="display: flex; justify-content: space-between;"> <div style="width: 70%;"> <p><input type="checkbox"/> Approved AWDOC/date _____</p> <p><input type="checkbox"/> Returned/date _____</p> <p><input type="checkbox"/> Denied effective date ____/01/____</p> </div> <div style="width: 25%; border: 1px solid black; padding: 5px;"> <p align="center">Benefits office authorization</p> <p>_____</p> <p>_____</p> </div> </div>
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<b>Employee information</b> (Please print)		Payroll/employee ID:	SSN	<input type="checkbox"/> Married <input type="checkbox"/> Single
Last name	First name	Middle initial	Email	Phone
<input type="checkbox"/> New Home mailing address?		City	State	ZIP
My spouse is <input type="checkbox"/> State <input type="checkbox"/> Education <input type="checkbox"/> County employee		Name	SSN	
<b>Agency</b>	Name	Agency #	Location code	Work phone

**Change reasons** (Please attach supporting documentation to this Change Request Form)

The **EVENT DATE IS** \_\_\_\_\_ and I have circled the appropriate exception number below. By signing this document I am indicating I wish to make a change to my benefit options under the plan. I hereby affirm this change is due to the allowable midyear change as checked below. I understand I have 30 days from the indicated event date to request applicable changes to my benefit options for this plan year.

**Allowable midyear changes** within plan guidelines are listed below.

<p><input type="checkbox"/> 1. <b>Marital status</b> (marriage/divorce/separation documentation required).</p> <p><input type="checkbox"/> 2. <b>Number of dependents.</b></p> <p><input type="checkbox"/> 3. <b>Employment status</b> affecting eligibility for employee, spouse or dependent.</p> <p><input type="checkbox"/> 4. <b>Dependent eligibility.</b></p> <p><input type="checkbox"/> 5. <b>Change of residence</b> for employee or dependent.</p> <p><input type="checkbox"/> 6. <b>Adoption</b> proceedings, starting or ending.</p> <p><input type="checkbox"/> 7. <b>Judgments, decrees/orders</b> (allowed for health, HCRA and dental).</p>	<p><input type="checkbox"/> 8. <b>Medicare or Medicaid</b> (allowed for health and HCRA only, and limited to two changes per year for Medicaid).</p> <p><input type="checkbox"/> 9. <b>Dependent care</b>, significant cost/coverage change.</p> <p><input type="checkbox"/> 10. <b>Employer plan coverage change</b> for spouse or dependent(s).</p> <p><input type="checkbox"/> 11. <b>FMLA</b> leave.</p> <p><input type="checkbox"/> 12. <b>Other</b>, specify (administrative, adjustments, etc.).</p>
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<b>Change</b>							
(a) <input type="checkbox"/> <b>EMPLOYEE TERMINATION</b>	<input type="checkbox"/> DEATH <input type="checkbox"/> DISCHARGE <input type="checkbox"/> RESIGNATION <input type="checkbox"/> RETIREMENT <input type="checkbox"/> USERRA <input type="checkbox"/> VOBO					Last day worked	
(b) <input type="checkbox"/> <b>TRANSFER</b>	From agency #	Location code	End date	To agency #	Location code	Begin date	
(c) <input type="checkbox"/> <b>EMPLOYMENT STATUS</b>	<input type="checkbox"/> REHIRE <input type="checkbox"/> LWOP <input type="checkbox"/> WORKER'S COMP <input type="checkbox"/> DISABILITY <input type="checkbox"/> FMLA (family leave)				Date left	Date returned	
(d) <input type="checkbox"/> <b>CORRECTION</b>	<input type="checkbox"/> NAME	<input type="checkbox"/> SSN	<input type="checkbox"/> BIRTHDATE	From	To	For	
(e) <input type="checkbox"/> <b>DROPPED COVERAGE</b> (For nonpayment of premiums)	<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> DEPENDENTS		Effective date	_____/01/____		Reason	
(f) <input type="checkbox"/> <b>PLAN CHANGE</b> If any qualifying exception or administrative error requires or results in a plan change, designate below the new plan and new PCP or PCD.							
From (current plan)		To (new plan)		PCP/PDP	Effective date		
					_____/01/____		
(g) <input type="checkbox"/> <b>REIMBURSEMENTS ACCOUNTS</b>							
				Current		Change to	
				\$ _____		\$ _____	
<input type="checkbox"/> <b>Benny Card</b>				DEPENDENT CARE (annual minimum = \$600, annual maximum = \$5,000)		\$ _____	
				HEALTH CARE (annual minimum = \$120, annual maximum = \$2,750)		\$ _____	

(h) <input type="checkbox"/> <b>HEALTH SAVINGS ACCOUNT – HSA</b> (To be used in conjunction with the HDHP.)	Current \$ _____	Change to \$ _____
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**Employee/dependent information** (Complete and check coverage boxes.)  
 List only individuals being added or dropped on the health, dental, vision or Dependent Life plans.

<b>Spouse:</b>  Add <input type="checkbox"/> Drop <input type="checkbox"/>  <input type="checkbox"/> <b>Health</b> <input type="checkbox"/>  <input type="checkbox"/> <b>Dental</b> <input type="checkbox"/>  <input type="checkbox"/> <b>Vision</b> <input type="checkbox"/>  <input type="checkbox"/> <b>Dep. Life</b> <input type="checkbox"/>	Name _____	SSN _____		
	Date of birth _____	<input type="checkbox"/> M <input type="checkbox"/> F		
	Address _____	City _____	State _____	ZIP _____
	Plan name: <input type="checkbox"/> Premier <input type="checkbox"/> Standard <input type="checkbox"/> Low	Primary care physician _____		
		Primary care dentist _____		

<b>Child:</b>  Add <input type="checkbox"/> Drop <input type="checkbox"/>  <input type="checkbox"/> <b>Health</b> <input type="checkbox"/>  <input type="checkbox"/> <b>Dental</b> <input type="checkbox"/>  <input type="checkbox"/> <b>Vision</b> <input type="checkbox"/>  <input type="checkbox"/> <b>Dep. Life</b> <input type="checkbox"/>	Name _____	SSN _____		
	Date of birth _____	<input type="checkbox"/> M <input type="checkbox"/> F		
	Address _____	City _____	State _____	ZIP _____
	Plan name: <input type="checkbox"/> Premier <input type="checkbox"/> Standard <input type="checkbox"/> Low	Primary care physician _____		
		Primary care dentist _____		

<b>Child:</b>  Add <input type="checkbox"/> Drop <input type="checkbox"/>  <input type="checkbox"/> <b>Health</b> <input type="checkbox"/>  <input type="checkbox"/> <b>Dental</b> <input type="checkbox"/>  <input type="checkbox"/> <b>Vision</b> <input type="checkbox"/>  <input type="checkbox"/> <b>Dep. Life</b> <input type="checkbox"/>	Name _____	SSN _____		
	Date of birth _____	<input type="checkbox"/> M <input type="checkbox"/> F		
	Address _____	City _____	State _____	ZIP _____
	Plan name: <input type="checkbox"/> Premier <input type="checkbox"/> Standard <input type="checkbox"/> Low	Primary care physician _____		
		Primary care dentist _____		

**Employee authorization**

I authorize and agree to any NECESSARY salary reduction to implement my elections. **I UNDERSTAND MY ELECTIONS ARE BINDING AND IRREVOCABLE AND WILL REMAIN IN EFFECT FOR THE FULL PLAN YEAR UNLESS I EXPERIENCE AN ALLOWABLE MIDYEAR CHANGE EVENT.** I understand I have 30 days from the event to request any applicable changes to my options for this plan year. I also understand any money left in the reimbursement account(s) will be forfeited at the end of the plan year grace period or upon my termination with the state.

Employee signature	Date	
<b>X</b> _____	_____	_____/_____ Agency and group

**Benefits coordinator authorization** – please date and sign.

The enrollment form must be sent to the Employees Benefits Department of HCM accompanied by any additional documentation for enrollment as required (e.g., Exclusion for Spouse Coverage, proof of other group coverage, Supplemental Life applications, etc.). If all requested information is not completed on this form by either the employee or the coordinator, the form will be returned for completion, which could result in a delay in processing or denial of claims.

Benefits coordinator	Phone	Date
<b>X</b> _____	_____	_____
BC email _____		

**IMPORTANT!** Send form and all attachments to the Employees Benefits Department of HCM.