



**DECREASE ELECTION FORM FOR  
SUPPLEMENTAL LIFE INSURANCE**

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

For active state employees who wish to decrease coverage in their  
Supplemental Life Insurance.

**PLEASE PRINT FULL NAME** \_\_\_\_\_

hereby reduce my Supplemental Life Insurance coverage to:

\$ \_\_\_\_\_ (20,000 increments only)

Signed \_\_\_\_\_

Social Security number \_\_\_\_\_

Date \_\_\_\_\_

Agency/location \_\_\_\_\_

Benefits coordinator \_\_\_\_\_

Date \_\_\_\_\_

**(Please give form to your benefits coordinator)**

Benefits coordinators: Please send this form to **EBD**. **Do not send to EGID.**