OKLAHOMA
Office of Management & Enterprise Services

Human Capital Management
Employee Benefits Department

CHANGE REQUEST FORM

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

COORDINATOR USE ONLY (must complete)

Event date _____

Requested effective date_____/01/_____

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).

BENEFITS OFFICE USE ONLY

☐ Approved
AWDOC/date _____

☐ Returned/date _____

☐ Denied
effective date ___/01/___

Benefits office authorization
_____
_____

Employee information (Please print)	Payroll/employee ID:	SSN	☐ Married ☐ Single

Last name	First name	Middle initial	Email	Phone

☐ New address? Home mailing address	City	State	ZIP

My spouse is ☐ State ☐ Education ☐ County employee	Name	SSN

Agency	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.

☐ 1. **Marital status** (marriage/divorce/separation documentation required).
☐ 2. **Number of dependents.**
☐ 3. **Employment status** affecting eligibility for employee, spouse or dependent.
☐ 4. **Dependent eligibility.**
☐ 5. **Change of residence** for employee or dependent.
☐ 6. **Adoption** proceedings, starting or ending.
☐ 7. **Judgments, decrees/orders** (allowed for health, HCRA and dental).
☐ 8. **Medicare or Medicaid** (allowed for health and HCRA only, and limited to two changes per year for Medicaid).
☐ 9. **Dependent care**, significant cost/coverage change.
☐ 10. **Employer plan coverage change** for spouse or dependent(s).
☐ 11. **FMLA** leave.
☐ 12. **Other**, specify (administrative, adjustments, etc.).

Change

(a) ☐ **EMPLOYEE TERMINATION**	☐ DEATH ☐ DISCHARGE ☐ RESIGNATION ☐ RETIREMENT ☐ USERRA ☐ VOBO				Last day worked	
(b) ☐ **TRANSFER**	From agency #	Location code	End date	To agency #	Location code	Begin date
(c) ☐ **EMPLOYMENT STATUS**	☐ REHIRE ☐ LWOP ☐ WORKER'S COMP ☐ DISABILITY ☐ FMLA (family leave)				Date left	Date returned
(d) ☐ **CORRECTION**	☐ NAME ☐ SSN ☐ BIRTHDATE			From	To	For
(e) ☐ **DROPPED COVERAGE** (For nonpayment of premiums)	☐ EMPLOYEE ☐ DEPENDENTS			Effective date _____/01/_____	Reason	

(f) ☐ **PLAN CHANGE** 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) ☐ **REIMBURSEMENTS ACCOUNTS**

		Current	Change to
☐ **Benny Card**	DEPENDENT CARE (annual minimum = $600, annual maximum = $5,000)	$____	$____
	HEALTH CARE (annual minimum = $120, annual maximum = $2,700)	$____	$____

Change cont. Last name _____ Date _____ SSN _____

(h) ☐ **HEALTH SAVINGS ACCOUNT – HSA**
(To be used in conjunction with the HDHP.)

Current $_____ Change to $_____

Employee/dependent information (Complete and check coverage boxes.)

List only individuals being added or dropped on the health, dental, vision or Dependent Life plans.

Spouse:

Add / Drop

☐ **Health** ☐
☐ **Dental** ☐
☐ **Vision** ☐
☐ **Dep. Life** ☐

Name			SSN
Date of birth	☐ M ☐ F		
Address	City	State	ZIP
Plan name: ☐ Premier ☐ Standard ☐ Low	Primary care physician		
	Primary care dentist		

Child:

Add / Drop

☐ **Health** ☐
☐ **Dental** ☐
☐ **Vision** ☐
☐ **Dep. Life** ☐

Name			SSN
Date of birth	☐ M ☐ F		
Address	City	State	ZIP
Plan name: ☐ Premier ☐ Standard ☐ Low	Primary care physician		
	Primary care dentist		

Child:

Add / Drop

☐ **Health** ☐
☐ **Dental** ☐
☐ **Vision** ☐
☐ **Dep. Life** ☐

Name			SSN
Date of birth	☐ M ☐ F		
Address	City	State	ZIP
Plan name: ☐ Premier ☐ Standard ☐ 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

X _____ Date _____ _____/_____

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

X _____ _____ _____

BC email

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

Print Form with Information **Clear Form**

Revised July 2020