



EMPLOYEES BENEFITS DEPARTMENT
Human Capital Management
Office of Management and Enterprise Services
 2101 N. Lincoln Blvd., Room 560, Oklahoma City, Oklahoma, 73105
 405-522-1190 or 1-800-219-8115

DEPENDENT ATTACHMENT FORM
(For Additional Dependents)

- Submitted with the Change Form
- Submitted with the New Hire Form
- Submitted with the Option Period Form

Employee Name: _____ SSN#: _____

Agency Name: _____ Agency #: _____

If you are a new hire enrolling in an HMO or prepaid dental plan designate a PCP and PCD for each child. Please list ONLY individuals being added or dropped on the health, dental, dependent life, &/or vision plans.

Child: Name: _____ SSN#: _____

_____ Add _____ Drop DOB: _____ Sex: _____

Health

_____ Add _____ Drop Address: _____

Dental

_____ Add _____ Drop Primary Care Physician (PCP): _____

Vision

_____ Add _____ Drop Primary Care Dentist (PCD): _____

Dependent Life

Child: Name: _____ SSN#: _____

_____ Add _____ Drop DOB: _____ Sex: _____

Health

_____ Add _____ Drop Address: _____

Dental

_____ Add _____ Drop Primary Care Physician (PCP): _____

Vision

_____ Add _____ Drop Primary Care Dentist (PCD): _____

Dependent Life

I hereby authorize and agree to a salary reduction, if necessary, to implement my elections. I understand my elections are binding and irrevocable and will remain in effect for the Plan Year unless I experience an allowable midyear change and provide documentation within 30 days of such event. I also understand that any money left in the reimbursement account(s) will be forfeited after the end of the Plan Year.

Employee Signature: _____ **Date:** _____

If you are a DHS employee, list your county/division location: _____

The original Change form or New Hire form plus documentation must be sent to the Employees Benefits Department of HCM. Copies should be retained by the Benefits Coordinator and must be available at any time upon request from the Employees Benefits Department of HCM. If all requested information is not completed on this form by either the employee Or the Benefits Coordinator, it will be returned for completion, which could result in a delay or denial of the request.

Benefits Coordinator Signature: _____ **Date:** _____

BC Phone Number: _____ **Email:** _____