



EMPLOYEE BENEFITS DEPARTMENT
Human Capital Management
Office of Management and Enterprise Services
2401 N. Lincoln Blvd., Suite 106, Oklahoma City, Oklahoma, 73105
405-522-1190 or 1-800-219-8115

DECREASE ELECTION FORM
For
SUPPLEMENTAL LIFE INSURANCE

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)
Benefit Coordinators – Please send this form to EBD. Do not send to EGID.