



EMPLOYEE BENEFITS DEPARTMENT
Human Capital Management
Office of Management and Enterprise Services
2401 N. Lincoln Blvd., Oklahoma City, OK 73105
405-522-5528 or 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**.