

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

DEPENDENT ATTACHMENT FORM
(For Additional Dependents)

- Submitted with the Change Form
- Submitted with the Newly Eligible 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: Health Name: _____ SSN#: _____
_____ Add _____ Drop DOB: _____ Sex: _____
Dental
_____ Add _____ Drop Address: _____
Vision
_____ Add _____ Drop Primary Care Physician (PCP): _____
Dependent Life
_____ Add _____ Drop Primary Care Dentist (PCD): _____

Child: Health Name: _____ SSN#: _____
_____ Add _____ Drop DOB: _____ Sex: _____
Dental
_____ Add _____ Drop Address: _____
Vision
_____ Add _____ Drop Primary Care Physician (PCP): _____
Dependent Life
_____ Add _____ Drop Primary Care Dentist (PCD): _____

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:** _____

The Change form or Newly Eligible form plus documentation must be sent to the Employee Benefits Department of HCM. Copies should be retained by the Benefits Coordinator and must be available at any time upon request from the Employee 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:** _____