ORU ORAL ROBERTS UNIVERSITY

CHANGE FORM

Please fax form to (918) 495-7561 or e-mail to benefits@oru.edu

Enrolling/Changing: ❑ HEALTH ❑ PPO ❑ HDHP (high deductible)	❑ EE Life 1x 2x 3x (circle 1) ❑ Spouse Life $_____ ❑ Child Life
❑ DENTAL ❑ Critical Illness ❑ VISION ❑ Accident ❑ STD Disability	❑ Flex Acct ❑ Health ❑ Dependent Care ❑ HSA

REMINDER: *If you are making a change outside of your initial enrollment period, please include the appropriate documentation with this form, such as a copy of a marriage certificate, divorce decree, birth certificate, certificate of creditable coverage from prior carrier (for loss of coverage), etc.*

Effective Date of Change_____

Employee Z Number Z	Employer Name ORU		Position/Department
Employee Name Last	First	Middle Initial	Last 4 of Social Security Number xxx-xx- _ _ _ _
Street Address	City	State	ZIP code
Cell Telephone ( )	HomeTelephone ( )	Work Extension	Marital Status ❑Single ❑Married ❑Divorced ❑Widowed ❑Legally Separated

Change as indicated:

❑ Name Change *List former name:*_____

❑ Address/Phone Change *List former address/phone:*_____

Name Change as a Result of Marriage (requires copy of new social security card):

If a name change is being made as a result of marriage and the employee does not request the addition of any new eligible dependent(s) at this time, this form shall serve as waiver of dependent coverage and the procedure for late enrollment of dependent(s) shall apply to any subsequent request for dependent coverage. *Note: Outside of open enrollment, a copy of your marriage certificate is required with this form.*

Employee Signature_____ **Date**_____

Request to Add Dependent(s): *Please list all dependent(s) for whom you are requesting coverage. Attach a certificate of creditable coverage if outside open enrollment period.*

Name	Relationship	Social Security Number	Date of Birth	Sex	Disabled?	List Coverage Options

Does this dependent(s) have other coverage? If so, please list health insurance carrier(s):_____

Reason for change:_____ Date of change:_____

Request to Drop Coverage

Under the coverages issued to my employer, I do not wish coverage for:

❑ **Myself and my dependent(s)** ***(if any)***

❑ Spouse

❑ Child(ren) *List name(s):*_____

Reason for Change-Qualifying Event

❑ _____.

Examples: Loss of other coverage/Loss of eligibility (cannot be voluntary), terming employment,newborn, adoption, divorce, marriage, etc.

*NOTE: All qualifying events require legal documentation within **30 days** of the event.

Request to add and/or Change Pre-Tax Spending Accounts

☐ Health Flex Spending:	(per pay Period) $ Amount	_____
☐ Dependent Care Flex Spending:	(per pay period) $ Amount	_____
☐ Health Savings Account:	(per pay period) $ Amount	_____

Note:You cannot exceed the IRS allowable amounts per year and/or per household (if applicable). Payroll may adjust the election. HSA: you must be enrolled in the High Deductible Health Plan. You do not need a qualifying event to elect or adjust your HSA contributions.

Note: Changes must be made within 30 days of a qualifying event or during open enrollment only. Open Enrollment changes are required to be completed through the online portal.

By signing below I agree that all given information is true and correct:

Employee Signature_____ **Date**_____