☐ Tribal Adm
☐ IS Casino
☐ Outpost
☐ BTCA
☐ Surv

Employer Name and Affiliate (If Different)

Eastern Shawnee Tribe of Oklahoma
76-412125

CHANGE FORM

Open Enrollment/ Special Enrollment

INFORMATION ABOUT EMPLOYEE

Employee Name *(last, first, middle)*	Social Security #		
Name Change (If Changing) *(last, first, middle)*	Phone#		
Employee Street Address **(If Changing)**	City	State	Zip-Code

MAJOR MEDICAL COVERAGE CHANGES

(**Self Changes**) *circle*
Adding: ❑ **Yes** ❑ **No** **Medical** **Dental** **Vision** ***Basic or Buy-up*** **Life**
Deleting: ❑ **Yes** ❑ **No** **Medical** **Dental** **Vision** ***Basic or Buy-up*** **Life**
Comments:

(**Dependent Changes**) *circle*
Adding Dep.: ❑ **Yes** ❑ **No** **Medical** **Dental** **Vision** ***Basic or Buy-up*** **Life**
Deleting Dep.: ❑ **Yes** ❑ **No** **Medical** **Dental** **Vision** ***Basic or Buy-up*** **Life**
Comments:

List all Participants below effected by Change:

Dependent Name *(last, first, middle)*	Sex M/F	Social Security#	Date of Birth	Relationship	Other Coverage/Tribal?
Spouse:					
Child:					
Child:					
Child:					

Special Enrollment Rights: Verification MUST be presented with Change Order within 30 days of event. Qualifying events are birth of a child, adoption, marriage, dependent loss of coverage, or self -loss of coverage. Verification can be adoption documents, marriage certificate, divorce decree, COBRA and/or employer memo on letterhead with start and stop dates. New births can use the hospital 'Live Birth Certificate' and/or the state Birth Certificate. SS#'s can be provided at a later date upon receipt. Open Enrollment-no documentation req'd.

Reason for Change Requested:	Date of Family Status Change:		
Dependent Address *(If Different Than One Above for COBRA Notification)* Dependent Street Address:	City	State	Zip-Code

Comments:

FOR YOUR SIGNATURE

I AUTHORIZE MY EMPLOYER TO MAKE ANY SALARY DEDUCTIONS/REDUCTIONS NECESSARY FOR THE BENEFITS THAT I HAVE ELECTED FOR MYSELF OR MY ELIBILE DEPENDENTS. I CERTIFY THAT THE INFORMATION ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE. I REALIZE THAT I CANNOT CHANGE THIS BENEFIT ELECTION UNTIL THE NEXT OPEN ENROLLMENT PERIOD SET BY MY EMPLOYER, UNLESS I HAVE A "SPECIAL ENROLLMENT RIGHT" CHANGE BEFORE THAT TIME.

Employee Signature:	Date Signed:	Effective Date of Change:

This form along with verification of status change MUST be returned to the Benefits Office by the 15th of the month to meet enrollment timeline.