Return Completed Form to:
Archdiocese of Okla. City
Attn: Business Office
P.O. Box 32180
Oklahoma City, OK 73123

Change Election Request

EMPLOYEE NAME	SOCIAL SECURITY #
EMPLOYER NAME	EFFECTIVE DATE OF CHANGE:

Please Make the Following Marked Changes

(NOTE: Form must be completed in ink or typed - cannot be accepted if completed in pencil.)

REASON FOR CHANGE

☐ Marriage (Date of Marriage) _____
☐ Divorce (Date) _____
☐ Order of Court (Explain) _____
☐ Birth (Date) _____
☐ Other, specify _____

CHANGE OF NAME

FROM: _____
Please print full name
TO: _____
Please print full name

CHANGE OF COVERAGE

☐ Dep. Life ☐ AD&D ☐ Medical ☐ Dental ☐ Vision
☐ Remove Dependents Listed Below ☐ Spouse ☐ Child(ren)
You and/or your dependents may **NOT** re-enroll under this plan unless you have a HIPPA qualifying event.
☐ Add Dependents Listed Below ☐ Spouse ☐ Child(ren)

Dependent Information:

Full Name/Relationship*	Birthdate	Social Security Number

(* If stepchild, does he/she reside with employee at least six months per year? _____)
If application date is more than 30 days after marriage date or birth date evidence of insurability may be required. Please attach.

BENEFICIARY CHANGE

I hereby revoke all prior beneficiary designations and request the designation below.

PRINT FULL NAME (FIRST, M.I., LAST) RELATIONSHIP

Primary Beneficiary:_____
_____
Contingent Beneficiary (if applicable)_____
_____

Unless otherwise directed, proceeds will be paid in equal shares to the primary beneficiaries who survive the Insured; but if none survive, proceeds will be paid in equal shares to any contingent beneficiaries who survive the Insured. If no designated beneficiary survives the Insured, proceeds will be paid to the Insured's estate.

CHANGE OF ADDRESS

From: (Old Address)

_____ _____ _____ _____
Street Address City State Zip

To: (New Address)

_____ _____ _____ _____
Street Address City State Zip

_____ _____
(Signature of Insured) (Signature Date)