Benefit Enrollment Change Request Due to Qualified Life Event

Please fill out each independently

NOTE: You have 30 days from the date the status change was effective to make any eligible changes to your benefits enrollment. Requests due to family/job changes past 30 days can NOT be approved.

The following are requirements for coverage changes related to qualifying events including changes in family and/or job status: If you are adding dependents as a result of your qualifying event, you must complete the attached dependent verification worksheet(s) and provide proof of eligibility or their enrollment will not be accepted or processed.

- ☐
- ☐ All proper documentation and additional forms must be attached at the time of submission (marriage license, divorce decree, spouse's employer statement, proof of new coverage, etc.)
- ☐ Medical options may be changed only if certain circumstances apply; for example, changing from $1200 Deductible Option to $1500 Deductible Option. See "Changing Your Benefit Options" section of the Benefits Handbook.
- ☐ All changes must be consistent with the qualifying event. See the "Changing Your Benefits Options" section of the Benefits Handbook for details.

  Any changes to the Dependent Care Reimbursement accounts must include the date the contribution is to begin or change.

Return completed status change form, all required documentation and dependent verification worksheets to:

INTEGRIS Health Human Resources
3520 NW 58th St Suite A-100
Oklahoma City, Oklahoma 73112
Scan and Email: BenefitForms@integrisok.com
Fax 405-979-8343

If you have questions about your benefits or how to complete this form, please contact Human Resources Customer Service at 405-949-4045 or HRCustomerService@integrisok.com

INTEGRIS Health Life Event Change Request

This form is only to be used if you have a change during open enrollment.
Changes outside open enrollment must be done online at www.myintegrisbenefits.com

Use this form to indicate changes to your 2020 benefits.

Name:_____ Caregiver ID:_____ Date_____

Reason for Change:_____ Date of Change:_____

Phone: _____ Email: _____

1a. Please list any dependents including yourself that you would like to add or drop coverage on

Name Caregiver / Spouse / Children	Medical	Dental	Vision
	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
		☐ Limited ☐ None ☐ Comprehensive	

* If your change in status allows you to change your medical plan, please complete box 1b. To find out if your status change qualifies, contact the HR office.

1b.

Deductible
☐ $1,500 ☐ $1,200 ☐ $900

☐ **Out of State dependent coverage option**

2. Caregiver Optional Life:

To change current coverage to a different multiple of pay, please check the appropriate box (EOI form required if increasing coverage from previous enrollment):

☐ None	☐ 1X	☐ 2X	☐ 3X	☐ 4X	☐ 5X	☐ 6X

3. Caregiver Optional AD&D:

To change current coverage to a different multiple of pay, please check the appropriate box

☐ None	☐ 1X	☐ 2X	☐ 3X	☐ 4X	☐ 5X	☐ 6X

4. Spouse Life:

Change current coverage level to (EOI form required if increasing coverage from previous enrollment):

☐ No Coverage	☐ $5,000	☐ Multiple of $10,000 up to $250,000 please specify amount: $_____

5. Spouse AD&D:

Change current coverage level to :

☐ No Coverage	☐ $5,000	☐ Multiple of $10,000 up

Please Continue to Next Page

Continued from Previous Page

Use this form to indicate changes to your 2020 benefits.

If you would like to make a change to your voluntary benefits, please contact a benefit specialist at 405.949.4045. Voluntary benefits include Accidental Injury, Critical Illness, Hospital Indemnity, Whole Life and InfoArmor.

6. Child Life

Change current coverage level to :

☐No Coverage	☐$2,000	☐$4,000	☐$8,000	☐$10,000

7. Child AD&D:

Change current coverage level to :

☐No Coverage	☐$2,000	☐$4,000	☐$8,000	☐$10,000

8. Caregiver Short-term Disability:

Change current coverage level to :

☐ No Coverage	☐ 60% Full-time only

9. Caregiver Long-term Disability:

Change current coverage level to :

☐ 40% Full-time only	☐ 60% Full-time only

10. Reimbursement Accounts:

To change your current contribution amount, please indicate your desired per pay period amount

Reimbursement Account	From	To	Date of Change	Location
Health Care ($3.85 min - $103.84 max)	$_____	$_____	N/A	N/A
Dependent ($3.85 min - $192.30 max)	$_____	$_____	____/____/_____	☐ The Children's Place ☐ Other

11. PPL Sell: ☐ I do not wish to sell PPL ☐ I wish to sell PPL - Number of PPL days you wish to sell:_____

Max days to sell by tenure:

0-4 years: up to 16 days | **5-9 years:** up to 21 days | **10-14 years:** up to 23 days | **15-19 years:** up to 26 days | **20+ years:** up to 28 days

12. Spouse Surcharge: please check any that apply

☐ I do not have a spouse
☐ My spouse is offered medical insurance through his/her employer
☐ My spouse is not offered medical insurance through his/her employer
☐ My spouse is not employed

13. Tobacco Surcharge: please check any that apply

☐ I do not use tobacco or nicotine products/devices
☐ I do use tobacco or nicotine products/devices
☐ I do not have a spouse
☐ My spouse does not use tobacco or nicotine products/devices
☐ My spouse does use tobacco or nicotine products/devices

Have you included the following?

☐ Documentation of Qualifying Event
☐ Dependent Verification Forms (if adding new dependents)
☐ Documentation for Dependents (if adding new dependents)
☐ Spouse Other Benefits Authorization Form

Authorization Statement

I understand the above request may have future consequences, such as providing evidence of insurability or tax implications. I acknowledge the above statements to be honest and valid circumstances under which I may change my benefits enrollment.

Signature_____ **Date:**_____

INTEGRIS Health Family/Job Status Change Request

This form is only to be used if you have a change during open enrollment.
Changes outside open enrollment must be done online at www.myintegrisbenefits.com

Use this form to indicate changes to your 2021 benefits.

Name:_____ Caregiver ID:_____ Date_____

Reason for Change:_____ Date of Change:_____

Phone: _____ Email: _____

1a. Please list any dependents including yourself that you would like to add or drop coverage on

Name Caregiver / Spouse / Children	**Medical**	**Dental**	**Vision**
	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
		☐ Limited ☐ None ☐ Comprehensive	

* If your change in status allows you to change your medical plan, please complete box 1b. To find out if your status change qualifies, contact the HR office.

1b. Medical Plan

Deductible Options
☐ $1,500 ☐ $1,200 ☐ $900

☐ **Out of State dependent coverage option**

2. Caregiver Optional Life:

To change current coverage to a different multiple of pay, please check the appropriate box (EOI form required if increasing coverage from previous enrollment):

☐ None	☐ 1X	☐ 2X	☐ 3X	☐ 4X	☐ 5X	☐ 6X

3. Caregiver Optional AD&D:

To change current coverage to a different multiple of pay, please check the appropriate box

☐ None	☐ 1X	☐ 2X	☐ 3X	☐ 4X	☐ 5X	☐ 6X

4. Spouse Life:

Change current coverage level to (EOI form required if increasing coverage from previous enrollment):

☐ No Coverage	☐ $5,000	☐ Multiple of $10,000 up to $250,000 please specify amount: $_____

5. Spouse AD&D:

Change current coverage level to :

☐ No Coverage	☐ $5,000	☐ Multiple of $10,000 up to $250,000 please specify amount: $_____

6. Child Life

Change current coverage level to :

☐No Coverage	☐$2,000	☐$4,000	☐$8,000	☐$10,000

7. Child AD&D:

Change current coverage level to :

☐No Coverage	☐$2,000	☐$4,000	☐$8,000	☐$10,000

Please Continue to Next Page

Use this form to indicate changes to your 2021 benefits.

Continued from Previous Page

8. Caregiver Short-term Disability:

Change current coverage level to :

☐ No Coverage	☐ 60% Full-time only

9. Caregiver Long-term Disability:

Change current coverage level to :

☐ 40% Full-time only	☐ 60% Full-time only

10. Reimbursement Accounts:

To change your current contribution amount, please indicate your desired per pay period amount

Reimbursement Account	From	To	Date of Change	Location
Health Care ($3.85 min - $105.76 max)	$_____	$_____	N/A	N/A
Dependent ($3.85 min - $192.30 max)	$_____	$_____	____/____/_____	☐ The Children's Place ☐ Other

11. PPL Sell: ☐ I do not wish to sell PPL ☐ I wish to sell PPL - Number of PPL days you wish to sell: _____

Max days to sell by tenure:

0-4 years: up to 16 days | **5-9 years:** up to 21 days | **10-14 years:** up to 23 days | **15-19 years:** up to 26 days | **20+ years:** up to 28 days

12. Voluntary Benefits:

To change or enroll in coverage please select the tier and coverage plan(s) you would like to add or drop

Coverage Tier	Accident	Hosp Indemnity	Crit Illness	Info Armor
☐ Caregiver Only	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
☐ Caregiver + Spouse	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
☐ Caregiver + Children	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
☐ Caregiver + Family	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop

If you would like to make a change to your voluntary benefits, please contact a benefit specialist at 405.949.4045.
Voluntary benefits include Accidental Injury, Critical Illness, Hospital Indemnity, Whole Life and Info Armor.

Use this form to indicate changes to your 2021 benefits.

13. Spouse Surcharge: please check any that apply

☐ I do not have a spouse
☐ My spouse is offered medical insurance through his/her employer
☐ My spouse is not offered medical insurance through his/her employer
☐ My spouse is not employed

14. Tobacco Surcharge: please check any that apply

☐ I do not use tobacco or nicotine products/devices
☐ I do use tobacco or nicotine products/devices
☐ I do not have a spouse
☐ My spouse does not use tobacco or nicotine products/devices
☐ My spouse does use tobacco or nicotine products/devices

15. Dependent(s) Surcharge: only for out of state dependents

☐ I am covering a spouse or child that lives out of state and wish to have out of state medical coverage

Have you included the following?

☐ Documentation of Qualifying Event
☐ Dependent Verification Forms (if adding new dependents)
☐ Documentation for Dependents (if adding new dependents)
☐ Spouse Employment Verification Form

Authorization Statement

I understand the above request may have future consequences, such as providing evidence of insurability or tax implications. I acknowledge the above statements to be honest and valid circumstances under which I may change my benefits enrollment.

Signature_____ **Date:**_____

HR USE ONLY:

Date Entered: _____Benefits Effective Date:_____HR Signature:_____

DEPENDENT VERIFICATION WORKSHEETS

Dear INTEGRIS Health caregiver,

As a part of our ongoing efforts to offer high quality health care and control health care costs for you and your family, INTEGRIS Health requires that all caregivers provide verification of dependent eligibility status before any dependents (spouse and/or children) are considered to be eligible for coverage. Required documentation is outlined on the Spouse and Dependent Child Worksheets that you will print from the INTEGRIS Health benefits enrollment website. If you elect any form of dependent coverage for any of the benefit plans, you will be required to submit the required documents on or before your benefits enrollment deadline.

Please review the Frequently Asked Questions below for further information:

Who qualifies as an eligible dependent?

- Your legal spouse as defined by Oklahoma law (in the event of a decree of divorce, annulment or legal separation, your spouse will no longer qualify as an eligible dependent);
- Children
  For medical, dental and vision coverage, your child up to their 26th birthday. Includes natural children, stepchildren, legally adopted children, children placed in your home while waiting for finalization of adoption, foster children and children for whom you or your spouse have been awarded legal guardianship. Coverage may be continued to any age if the dependent child is mentally or physically disabled and was a covered dependent before age 26.

What documentation do I need to provide?
The Dependent Child and Spouse Verification Worksheets describe the types of proof of eligibility that must be submitted by you to verify your dependent's eligibility for INTEGRIS Health benefits coverage. Some proof of eligibility examples include: copies of birth certificates, marriage certificate, tax return, proof of joint ownership, etc. **Include only page one of your tax return showing dependent information. Please black out all financial information and the first five digits of all Social Security numbers.** The rule of thumb is that we only need to see the information necessary to prove the dependent's relationship to the caregiver. As it pertains to financial information, ***" When in doubt, black it out!"***

What will happen if I don't provide the dependent documentation required for the Dependent Eligibility process? If you do not respond and submit your documentation by your enrollment deadline, your dependent(s) benefits coverage (medical, dental, vision, dependent life and dependent AD&D) under the INTEGRIS Health benefit plans will automatically be cancelled.

How will my personal information be used?
Your personal information will only be used to verify the eligibility of your dependents. INTEGRIS Health will treat all information it receives in connection with this dependent verification process as private and confidential.

Who should I contact if I have additional questions about the Dependent Eligibility process?
Contact INTEGRIS Health Human Resources Customer Service at 405-949-4045, Monday through Friday, between the hours of 8:00 a.m. and 5:00 p.m. for additional assistance.

DEPENDENT VERIFICATION WORKSHEET – SPOUSE

Caregiver Name: _____ Caregiver ID# _____
Daytime Contact Information: _____ Work Number: _____
Work Email: _____ (Requests for additional information, if needed, will be sent to you work email)
Spouse's Name: _____ Spouse's SSN: _____
Spouse's Date of Birth: _____

The sections below describe the type of documentation that **MUST** be submitted in order to verify your spouse's eligibility for coverage under INTEGRIS Health benefit plans. Once you determine which type of documentation you will submit to verify eligibility, please complete **Part 1** and **Part 3** for legally married or **Part 2** and **Part 3** for common law spouse. Check the corresponding box located by the option selected.

If a copy of the documentation cannot be provided, please check "None of the above applies." ***If you cannot provide documentation, this dependent is not eligible for coverage.***

Part 1 – Please select ONE option only

Proof of Marital Status:		**CHECK THE BOX(ES) THAT APPLY**
Option 1	Copy of caregiver's most recent Federal Tax Return*	☐
Option 2	Copy of Marriage Certificate ***AND*** one of the following: Copy of Proof of Joint Ownership (must be dated after January 1st of the current year, and include both the caregiver's and spouse's name). For example, mortgage statement, bank statement, or property tax statement.	☐
Option 3	If married this year, copy of Marriage Certificate	☐
Option 4	None of the above applies (this dependent is not eligible for coverage.)	☐

Part 2 – Please select ONE option only

Proof of Common Law Status:		**CHECK THE BOX(ES) THAT APPLY**
Option 1	Copy of caregiver's most recent Federal Tax Return*	☐
Option 2 (ONLY APPLIES IF YOUR COMMON LAW MARRIAGE WAS EFFECTIVE AFTER DEC. 31, LAST YEAR)	Copy of Common Law Marriage Affidavit (form available on HR*anytime* or contact HR Customer Service 405.949.4045) **AND** *two* of the following: Copy of Proof of Joint Ownership (must be dated after January 1st of the current year and include both the employee's and spouse's name). For example: mortgage statement, bank statement, or property tax statement.	☐
Option 3	None of the above applies (this dependent is not eligible for coverage.)	☐

Part 3 – REQUIRED: Select the statement that applies:

Verification of Current Status:		**CHECK THE BOX(ES) THAT APPLY**
Statement 1	I am currently legally married to: _____ I am currently in a common law marriage to: _____	☐
Statement 2	I was legally separated or divorced on the date provided below and have attached legal documentation for my separation or divorce Date of legal separation or divorce: _____	☐

***NOTE: Acceptable tax documentation samples: Federal Tax (1040 form or e-file confirmation page). Please include only page one of your tax return which shows your dependent information. "Black out" all financial information.**

DEPENDENT VERIFICATION WORKSHEET – SPOUSE

CERTIFICATION: I certify the information I have provided is true and correct, and that I am responsible to update the information I have provided in the event it changes. I understand the documentation will be reviewed and a determination will be made regarding my dependent's eligibility for coverage. I acknowledge that falsifying this information or failing to update this information will lead to cancellation of my dependent's coverage. Submission of this worksheet and documentation does not necessarily guarantee eligibility for benefits.

Caregiver Signature: _____ Date: _____

DEADLINE: Your deadline is 30 days from your hire date, or, if change is due to a change in Family or Job status, deadline is 30 days from the qualifying event. If change is due to open enrollment, deadline is last day of open enrollment. Failure to submit the required documentation by the deadline will result in your dependents being removed from all INTEGRIS Health benefit plans.

Please complete Parts 1, 2, and 3 as applicable and attach copies of supporting documentation to the back of this worksheet, or electronically, and mail to INTEGRIS Health Human Resources at the address below. *Please keep a copy of this worksheet for your records.*

INTEGRIS Health Human Resources
3520 NW 58th St Suite A-100
Oklahoma City, Oklahoma 73112
Scan and Email: BenefitForms@integrisok.com
Fax 405-979-8343

*For medical, dental and vision coverage children are eligible up to age 26 regardless of full-time student status, residency, financial support or marital status.

(Form must be returned by the appropriate deadline. New hire – enrollment deadline, Life Event – 30 days from date of life event, Open Enrollment – last day of open enrollment)

INTEGRIS HEALTH

DEPENDENT VERIFICATION WORKSHEET – CHILD

Caregiver Name: _____ Caregiver ID# _____
Daytime Contact Information: _____ Work Number: _____
Work Email: _____
(Requests for additional information, if needed, will be sent to you work email)

The sections below describe the type of documentation that **MUST** be submitted to verify your child(ren)'s eligibility. Eligible children* include natural children; stepchildren; legally adopted children; children placed in your home while waiting for finalization of adoption; foster children and children for whom you or your spouse have been awarded legal guardianship.

Follow the instructions below and fill out **ALL** sections that apply to your child(ren). For each section, check the corresponding box located beneath each child listed.

- List Child(ren)'s information in **Part 1**.
- If your child(ren) is under the age of 26, complete **Part 2**.
- If your child(ren) is totally disabled and under the age of 26, complete **Part 2 and Part 3**.
- Sign and date in **Certification** box.

Part 1 – List information for each child (use additional form is more than eight children) Print Clearly

Child #	Child Name	Gender	Social Security Number	Date of Birth
1				
2				
3				
4				
5				
6				
7				
8				

Part 2 – Required for each child – please do not submit this document without providing verification

Proof of Parenthood (Please select only **ONE** per Dependent)	Child #1	Child #2	Child #3	Child #4	Child #5	Child #6	Child #7	Child #8
Copy of birth certificate or birth record showing caregiver or eligible spouse** as parent								
Copy of final adoption order or placement order approved by the court**								
Copy of court documents showing caregiver or eligible spouse** as legal guardian (with signature or seal) OR divorce provisions for child(ren)								
Copy of caregiver's most recent Federal Tax Return *** **(see note below)** which shows the child(ren) as your dependent(s)								

**If your spouse is the child's parent, the Spouse Verification Worksheet must be completed to verify their eligibility.
***Acceptable tax documentation samples: Federal Tax (1040 form or other form). Please include only page one of your tax return which shows your dependent information. "**Black out**" all financial information.

Part 3 – Complete for each totally disabled child

Proof of Total Disability	Child #1	Child #2	Child #3	Child #4	Child #5	Child #6	Child #7	Child #8
Affidavit of Total Disability (form available online or contact HR Customer Service at 405-949-4045)								

DEPENDENT VERIFICATION WORKSHEET – CHILD

CERTIFICATION: I certify the information I have provided is true and correct, and that I am responsible to update the information I have provided in the event it changes. I understand the documentation will be reviewed and a determination will be made regarding my dependent's eligibility for coverage. I acknowledge that falsifying this information or failing to update this information will lead to cancellation of my dependent's coverage. Submission of this worksheet and documentation does not necessarily guarantee eligibility for benefits.

Caregiver Signature: _____ Date: _____

DEADLINE: Your deadline is 30 days from your hire date, or, if change is due to a change in Family or Job status, deadline is 30 days from the qualifying event. Failure to submit the required documentation by the deadline will result in your dependents being removed from all INTEGRIS Health benefit plans.

Please complete Parts 1, 2, and 3 as applicable and attach copies of supporting documentation to the back of this worksheet, or electronically, and mail to INTEGRIS Health Human Resources at the address below. *Please keep a copy of this worksheet for your records.*

INTEGRIS Health Human Resources
3520 NW 58th St Suite A-100
Oklahoma City, Oklahoma 73112
Scan and Email: BenefitForms@integrisok.com
Fax 405-979-8343

*For medical, dental and vision coverage children are eligible up to age 26 regardless of full-time student status, residency, financial support or marital status.

(Form must be returned by the appropriate deadline. New hire – enrollment deadline, Life Event – 30 days from date of life event, Open Enrollment – last day of open enrollment)

INTEGRIS Health Spouse Employment Verification Form

Section 1: Benefit Verification Information – To be completed by INTEGRIS Health caregiver

Caregiver ID Number: 8000_____

Caregiver Name:	Spouse Name:	Caregiver Phone:

Is your spouse employed? Yes ☐ No ☐

If self-employed list company name and description: _____

_____

If you checked No, explain: ☐Retired ☐Disabled ☐other_____

Please sign and date Section 1 below and return to *INTEGRIS Health.*

*If you checked **Yes**, please continue to the next question.*

Is your spouse employed by INTEGRIS Health? Yes ☐ No ☐

*If you checked **Yes**, please sign and date Section 1 below and return to INTEGRIS Health.*
*If you checked **No**, please sign and date Section 1 below. Please have your spouse complete Section 2.*
If you have questions regarding this letter, document requirements, or need assistance on where to obtain requested documentation, contact INTEGRIS Health Human Resources Customer Service at 405.949.4045.

By signing below, I hereby certify and warrant to INTEGRIS Health that all information on this form is true, correct and current as of the date signed. I further understand if I knowingly submit false information I may be subject to disciplinary action, up to and including termination of employment and appropriate legal recourse. Furthermore, my signature authorizes INTEGRIS Health to verify any and all documents provided and may contact any institution or organization to verify the facts as stated herein.

Caregiver Signature: _____ Date: _____

Section 2: Information Release Authorization – To be completed by INTEGRIS Health caregiver's spouse.

I authorize the use or disclosure of the requested information for the following purpose: Healthcare eligibility information provided to INTEGRIS Health will be used solely for determination of my eligibility for coverage under an INTEGRIS Health plan sponsored by INTEGRIS Health. This authorization for release of the above information to INTEGRIS Health will expire following termination of coverage.

I understand that I am signing this authorization voluntarily and that eligibility for coverage under an INTEGRIS Health plan sponsored by INTEGRIS Health will be affected if I do not sign this authorization. The consequences for my refusal to sign this authorization will be the application of the $35.00 per pay period surcharge for enrolling a spouse that is eligible for medical coverage through their employer.

Spouse Signature: _____ Date: _____

Section 3: Employer Verification – To be completed by Spouse's employer

Please provide the following information for your employee:

Is the above listed spouse (your employee) eligible to enroll for Major Medical coverage through your company during an open enrollment or qualifying event window? Yes ☐ No ☐

Company Name: _____

HR/Benefits Contact Name: _____

Contact Title: _____

Contact Signature & Date: _____

Contact Phone Number: _____

Submit completed form to INTEGRIS Health fax at 405.979.8343 or by mailing to 3520 NW 58th St., Ste. A-100, Oklahoma City, OK 73112.
You may also email this form to BenefitForms@integrisok.com

(Form must be returned by deadline or surcharge will apply. New hire – enrollment deadline, Life Event – 30 days from date of life event, Open Enrollment – last day of open enrollment)

Failure to fully complete and return this form will result in a $35.00 per pay period surcharge deduction from your pay check.

INTEGRIS Health Proof of Residence Form for Out-of-State Dependent(s)

Per INTEGRIS Health Medical Plan requirements, you must submit this form along with the following documents to be eligible for out-of-state dependent coverage. If this form, along with the required documentation, is not submitted you will not be enrolled in the out-of-state plan option.

Category I (one document showing proper name and address)

- Most recent real estate tax bill
- Mortgage statement
- Signed current lease plus proof of last two rent payments
- School registration form

Category II (two documents showing proper name and address)

- Gas bill
- Electric bill
- Water bill
- Car insurance or car registration
- Homeowner's or renter's insurance
- Telephone bill or Cable TV Bill within last 60 days day (land line only / **no** cell phones)

Dependent Name_____

Address_____

_____

INTEGRIS Health Caregiver/Policy Holder Name_____

Caregiver ID _____

Phone Number_____

I hereby state the above information is correct.

_____ _____

Signature of Dependent (if over age 18) Date

_____ _____

Signature of INTEGRIS Health Caregiver/Policy Holder Date

Submit completed form to INTEGRIS Health fax at 405.979.8343 or by mailing to 3520 NW 58th St., Ste. A-100, Oklahoma City, OK 73112.
You may also email this form to BenefitForms@integrisok.com
Please contact HR Customer Service at 405-949-4045 if you have any questions.

(Form must be returned by the appropriate deadline. New hire – enrollment deadline, Life Event – 30 days from date of life event, Open Enrollment – last day of open enrollment)

INTEGRIS HEALTH

FOR APPEALS ONLY

Benefits Enrollment - Appeal for Change

Completed appeal, with all necessary documentation (if applicable), must be submitted to:
HR Customer Service at BenefitForms@integrisok.com or by fax 405.979.8343.
Please allow 7-10 business days to receive a decision

(Please Print)

Caregiver Name: _____

Caregiver ID: _____ **Date of Appeal:** _____

Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Alternate Phone: _____

E-mail Address: _____

In the space below, please explain ***in detail*** the reason for the appeal request:

Caregiver Signature: _____ Date: _____

To be completed by Human Resources Only: **Received/Scanned by HRCS** _____

Decision: _____

Comments: _____

_____

_____

HR Signature: _____ Date: _____

Final Entry Scan by HRCS _____