Benefit Enrollment Change Request Due to Change in Family/Job Status

2019 forms included.
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:

Human Resources Customer Service
3520 NW 58th, Suite A-100
Oklahoma City, OK 73112
Fax 405.945.4480

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 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 2019 benefits.

Name:_____ Employee 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 Employee / 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. Employee 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. Employee 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: $_____

Please Continue to Next Page

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Use this form to indicate changes to your 2019 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. Employee Short-term Disability:

Change current coverage level to :

☐ No Coverage	☐ 60% Full-time only

9. Employee 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)				
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:_____

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 (need to complete the spouse other benefits form)
☐ My spouse is not offered medical insurance through his/her employer (need to complete the spouse other benefits form)
☐ 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)
☐ Form and documentation for Out-of-State dependent(s) if applicable)
☐ 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 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 2020 benefits.

Name:_____ Employee 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 Employee / 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. Employee 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. Employee 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 2020 benefits.

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8. Employee Short-term Disability:

Change current coverage level to :

☐ No Coverage	☐ 60% Full-time only

9. Employee 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:_____

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

1 2. Voluntary 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 Info Armor.

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

Use this form to indicate changes to your 2020 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 (need to complete the spouse other benefits form)
☐ My spouse is not offered medical insurance through his/her employer (need to complete the spouse other benefits form)
☐ 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 for them

Have you included the following?

☐ Documentation of Qualifying Event
☐ Dependent Verification Forms (if adding new dependents)
☐ Documentation for Dependents (if adding new dependents)
☐ Form and documentation for Out-of-State dependent(s) if applicable)
☐ 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:**_____

.....

HR USE ONLY:

Date Entered: _____Benefits Effective Date:_____HR Signature:_____

DEPENDENT VERIFICATION WORKSHEETS

Dear INTEGRIS employee,

As a part of our ongoing efforts to offer high quality health care and control health care costs for you and your family, INTEGRIS requires that all employees provide verification of dependent eligibility status before any dependents 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 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 benefits coverage. Some proof of eligibility examples include copies of birth certificates, marriage certificate, tax return, proof of joint ownership, etc. If you opt to furnish your tax return, **include only page one showing dependent information.** The rule of thumb is that we only need to see the information necessary to prove the dependent's relationship to the employee. 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 PAI) under the INTEGRIS 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 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 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.

Your personal information will only be used to verify the eligibility of your dependents. INTEGRIS 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 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

INTEGRIS

Employee Name: _____ Employee 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 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 employee's most recent Federal Tax Return***** **(see note below)** showing "Married filing jointly"	☐
Option 2	Copy of employee's most recent Federal Tax Return***** **(see note below)** showing "Married filing separately"	☐
Option 3	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 employee's and spouse's name). For example, mortgage statement, bank statement, or property tax statement.	☐
Option 4	If married this year, copy of Marriage Certificate	☐
Option 5	None of the above applies	☐

Part 2 – Please select ONE option only

Proof of Common Law Status:		**CHECK THE BOX(ES) THAT APPLY**
Option 1	Copy of employee's most recent Federal Tax Return***** **(see note below)** showing "Married filing jointly"	☐
Option 2	Copy of employee's most recent Federal Tax Return***** **(see note below)** showing "Married filing separately"	☐
Option 3 (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 **Note: if Option 3 is chosen, to ensure your dependent status matches your tax filing status you will be required to provide a copy of your Federal Tax Return by October 15th.**	☐

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.

Employee 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 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 Human Resources at the address below. *Please keep a copy of this worksheet for your records.*

INTEGRIS Human Resources
3520 NW 58th St Suite A-100
Oklahoma City, Oklahoma 73112
Scan and Email: HRCustomerService@integrisok.com
Fax 405-945-4480

*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.

DEPENDENT VERIFICATION WORKSHEET – CHILD

INTEGRIS

Employee Name: _____ Employee 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)

Child Name	Gender	Social Security Number	Date of Birth	State of Residence

Part 2 – Required for each child – please do not submit this document without providing verification. ***If you cannot provide documentation your dependent is not eligible for coverage.***

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 employee or eligible spouse** as parent								
Copy of final adoption order or placement order approved by the court**								
Copy of court documents showing employee or eligible spouse** as legal guardian (with signature or seal)								
Copy of employee'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.

Employee 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 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 Human Resources at the address below. *Please keep a copy of this worksheet for your records.*

INTEGRIS Human Resources
3520 NW 58th St Suite A-100
Oklahoma City, Oklahoma 73112
Scan and Email: HRCustomerService@integrisok.com
Fax 405-945-4480

*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.

For Appeals Only

INTEGRIS

Benefits Enrollment - Appeal for Change

Completed appeal with all necessary documentation (if applicable) must be submitted to:
HR Customer Service at interoffice 001.7062
**Appeals generally take 5-10 business days to receive a disposition*

Name: _____EMPL ID: _____
Please Print

Address: _____Apt#_____
City: _____ State: _____ Zip: _____
Work Phone: _____ Alternate Phone: _____
E-mail Address: _____

Date: _____

In the space below, please summarize the reason for the appeal request: