Frates Benefit Administrators
13439 Broadway Extension Suite 110
Oklahoma City, OK 73114
Ph: (800) 850-7166 Fax: (405) 775-5991

Change Request Form

Department **Member ID Number**

Last Name **First** **MI** **Social Security Number**

Address **Apt No.** **City** **State** **Zip Code**

Home Telephone **Work Telephone** **E-mail Address**

CHANGE OF PERSONAL INFORMATION

☐ Change my address/phone as indicated above. ☐ Change my name as shown above. My former name was _____

CHANGE OF COVERAGE

Offer COBRA? ☐ Yes ☐ No

☐ Terminate all coverage effective _____ Reason _____

☐ Terminate HSA Contributions effective _____ Reason _____

☐ HSA Contribution Amount _____

☐ Reinstate all coverage effective _____ Reason _____

☐ **My NEW Plan elections are:** Effective date: _____

COVERAGE ENROLLMENT LEVEL: ☐ SINGLE ☐ EE + SPOUSE ☐ EE + CHILDREN ☐ FAMILY ☐ I DO NOT WISH TO ENROLL

MEDICAL PLAN SELECTION: ☐ TRADITIONAL PLAN ☐ BASIC PLAN ☐ HD PLAN

ADDING DEPENDENTS

Reason for Adding Effective Date

SPOUSE

Spouse's Full Name	Date of Marriage	Date of Birth	Social Security Number
Employed By	Covered by other Insurance, Medicare or COBRA? * **(Please include a copy of the ID card)** ☐ Yes ☐ No		If Yes, Name of Plan
Group Number	ID Number	Effective Date	
Health Plan Address	City	State	Zip Code / Phone Number

DEPENDENTS

Dependent's Full Name	Relationship	Sex	Date of Birth	Social Security Number
Employed By	Is dependent eligible for Insurance through their employer? ☐ Yes ☐ No	Covered by other Insurance, Medicare or COBRA? * **(Please include a copy of the ID card)** ☐ **Yes** ☐ **No**		If Yes, Name of Plan
Group Number	ID Number	Effective Date		
Health Plan Address	City	State	Zip Code	Phone Number

Dependent's Full Name	Relationship	Sex	Date of Birth	Social Security Number
Employed By	Is dependent eligible for Insurance through their employer? ☐ Yes ☐ No	Covered by other Insurance, Medicare or COBRA? * **(Please include a copy of the ID card)** ☐ **Yes** ☐ **No**		If Yes, Name of Plan
Group Number	ID Number	Effective Date		
Health Plan Address	City	State	Zip Code	Phone Number

*** If you have indicated your dependent(s) are covered under another plan, please provide a copy of the ID card or a Certificate of Creditable Coverage from the prior carrier. If you have any questions regarding this information, please contact our office.**

DROPPING DEPENDENTS

Dependent's Name		**The dependent is:** ☐ Deceased ☐ Divorced ☐ Married ☐ Covered by other plan ☐ Exceeds minimum age ☐ Other: _____
Relationship	Effective date of change	
Dependent's Name		**The dependent is:** ☐ Deceased ☐ Divorced ☐ Married ☐ Covered by other plan ☐ Exceeds minimum age ☐ Other: _____
Relationship	Effective date of change	
Dependent's Name		**The dependent is:** ☐ Deceased ☐ Divorced ☐ Married ☐ Covered by other plan ☐ Exceeds minimum age ☐ Other:_____
Relationship	Effective date of change	

I understand that these changes will not become effective until approved:

Employee Signature **Date** **Employer Verification / Authorized Signature** **Date**