HealthSmart
SMARTER HEALTHCARE SOLUTIONS

P.O. Box 42096 ▪ Oklahoma City, OK 73123-3005 ▪ 800.825.3540

Service Request

Instructions

1. This form is used to change various items on your benefits coverage.
2. Complete the contact information in the section below.
3. Fill in ONLY those areas that you are requesting be changed.
4. **BE SURE TO PLACE YOUR SIGNATURE AT THE BOTTOM OF THIS FORM.**
5. Return completed form to your Human Resources Department.

Employer Name	Group Number	Social Security Number
Employee Name (Last, First, Middle Initial)	Phone Work	Phone Home
	Email	

CHANGE CONTACT INFORMATION

1.	**Change Name** of ☐ Employee ☐ Dependent	Reason:	☐ Male ☐ Female
	Former Name	New Name	
2.	**Change Contact Info** for ☐ Employee ☐ Dependent	Name	
	New Address (Street, City, State, Zip)	Phone Work / Phone Home	
		Email	

CHANGE COVERAGE

3.	**Cancellation of Coverage**	Cancel all coverages Effective (date):		Reason for canceling coverage:	
4.	**Reinstatement of Coverage**	Date coverage previously terminated:		Desired reinstatement date:	
		Reason for termination:			
5.	**Leave of Absence**	Date	Reason	Date of Expected Return	Authorized by:
6.	**Change of Coverage**	From: ☐ Single / ☐ Employee & Spouse / ☐ Employee & Child(ren) / ☐ Family / ☐ Life Insurance Only		To: ☐ Single / ☐ Employee & Spouse / ☐ Employee & Child(ren) / ☐ Family / ☐ Life Insurance Only / ☐ Retiree	
		Date of last marriage:			

7. **Add Dependents or Drop Dependents**

Add or Drop	Dependent Name (Last, First, MI)	Social Security No.	Relationship to You	Birthdate	Where Employed
☐ Add ☐ Drop					
☐ Add ☐ Drop					
☐ Add ☐ Drop					
☐ Add ☐ Drop					

7a. Reason for dropping dependent's coverage:

Complete 7b thru 7e if adding dependent coverage.

7b. Do any dependents listed above reside with the employee on a permanent basis? ☐ Yes ☐ No
If no, please provide name and address for this dependent:

7c. Are any dependents listed disabled or handicapped? ☐ Yes ☐ No If yes, please list who is disabled and the nature of the disability:

7d. Are any dependents listed eligible or receiving Medicare? ☐ Yes ☐ No
If yes, please explain:

7e. Are any dependents listed eligible for any other group coverage? ☐ Yes ☐ No
If yes, please give details:

8. **Beneficiary Change** In accordance with the provisions of the Plan, I hereby elect to change my beneficiary as follows:

Primary Beneficiary (full legal name)	Relationship to you	Birthdate
Contingent Beneficiary (full legal name)	Relationship to you	Birthdate

Signatures:	Employee	Date	Employer/HR	Date