



## Oklahoma Conference Board of Pensions & Health Benefits

EMPLOYER AUTHORIZATION  
CHANGE IN STATUS/REVOCAION OF BENEFITS ELECTION FORM

Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Employee Name (please print): \_\_\_\_\_ SSN: \_\_\_\_\_

Employee Address (or forwarding address): \_\_\_\_\_ Employee Phone #: \_\_\_\_\_

City

State

Zip

Effective \_\_\_\_\_, the employer authorizes a change or revocation of the benefit elections selected online with the Oklahoma Conference Board of Pension & Health Benefits health insurance/Cafeteria Plan with respect to the following changes in coverage: (Please check all that apply)

	Change	Termination
Medical Insurance Coverage	_____	_____
Dental Coverage	_____	_____
Vision Coverage	_____	_____
FSA - Medical Reimbursement	_____	_____
FSA - Dependent Care Assistance	_____	_____
FSA - HSA Contributions	_____	_____

Please check below the reason for the elected benefit change in status/termination. Benefits may only be changed under the following circumstances and changes must be acceptable under the Regulations issued by the Department of Treasury.

We certify that the following has incurred allowing the following change in status/termination of benefits:

- \_\_\_\_\_ Marriage
- \_\_\_\_\_ Divorce
- \_\_\_\_\_ Birth, adoption of a child
- \_\_\_\_\_ Death of spouse and/or dependent
- \_\_\_\_\_ Termination of employed by employee, spouse or dependent
- \_\_\_\_\_ Switching from part-time to full-time (or vice-versa) employment by employee or spouse or a reduction or increase of hours.
- \_\_\_\_\_ Employee or spouse have taken an unpaid Leave of Absence
- \_\_\_\_\_ Employee dependent satisfies or ceases to satisfy the requirements for coverage

The Benefits Office may require you to provide evidence to document the event which requires the change of election.

**Termination** of benefits will be **administered by the Conference Benefits Office** upon the receipt of this form.

**Qualified changes** to an employee's record must be initiated by the employee. It is the responsibility of the employee to go online and make the necessary changes online at [www.okumc.org/fsa](http://www.okumc.org/fsa). Failure to change enrollment will result in **no change in benefits**.

\_\_\_\_\_  
Employee Signature (if available)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Church or Agency Signature

\_\_\_\_\_  
Date



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