



Open Enrollment Correction Request Form

Office use only

Approved by: _____

Approved date: _____

Effective date: _____

This form must be submitted to your employer no later than October 31.

Employee information

Last name	First name	M.I.
Member ID, E number or Social Security number	Gender ☐ M ☐ F ☐ Other	Date of birth (mm/dd/yyyy)
Home phone number	Work phone number	Cell phone number
May OEGB send text messages to this number? Standard text message and data rates apply.		☐ Yes ☐ No
Address ☐ Check if new address		Apartment or space#
City	State	ZIP
		County

What is the correction for?

Describe the requested correction.

Who is this correction for? ☐ Self

☐ Spouse ☐ Domestic partner	Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F ☐ Other
Last name	First name	M.I.
Child of ☐ Self ☐ Spouse ☐ Domestic partner	Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F ☐ Other
Last name	First name	M.I.
Child of ☐ Self ☐ Spouse ☐ Domestic partner	Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F ☐ Other
Last name	First name	M.I.
Child of ☐ Self ☐ Spouse ☐ Domestic partner	Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F ☐ Other
Last name	First name	M.I.

What change or action would you like to see take place?

If applicable, please list the name of the plan(s) you would like to enroll in, change or cancel, as well as who is to be covered under each.

Employee signature and authorization

By signing below, I authorize my employer to correct my enrollment.

Employee signature

Date

Send this form to your employer no later than October 31.