Open Enrollment Correction Request Form

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 OEBB 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

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