**EMPLOYEES BENEFITS COUNCIL**
**120 N. Robinson, Suite 1100**
**Oklahoma City, Oklahoma 73102**
**405-232-1190 or 1-800-219-8115**

# EMPLOYEE PREMIUM REFUND REQUEST

**Date received by EBC Accounting: _____**
**Name _____ SSN _____**
**Agency Name_____ Agency#/Loc _____**
**Period & specific reason for refund: _____**

| | Name of Carrier | Enrolled Premium Amount | Premium Amount Paid | Refund Amount Due | Refund to Employee | Refund to Agency HB2928 |
|---|---|---|---|---|---|---|
| Health | | | | | | |
| Dental | | | | | | |
| Life | | | | | | |
| Supp Life | | | | | | |
| Dep Life | | | | | | |
| Disability | | | | | | |
| Vision | | | | | | |
| Spending Account | | | | | | |

**Total Refund Due per Period: $_____ $_____ $_____**

**Total Refund requested: for _____ period(s) x $ _____ = $ _____**
**Total Employee Refund requested: for _____ period(s) x $ _____ = $ _____**
**Total Agency Refund requested: for _____ period(s) x $ _____ = $ _____**

**In accordance with Title 87:20-31-2 of the rules of the Oklahoma State Employees Benefits Council, here are the rules that apply to receiving refunds for premiums: (A) Responsibility of participant to notify the Coordinator of changes in eligibility. It is the participant's duty to notify his/her coordinator of any changes in eligibility for himself, his spouse, or his dependents. Any refund of payment for any over deduction shall be made only when the Council is notified in writing no later than sixty (60) days from the actual date of the over deduction. No refund will be made for over deductions which occurred more than sixty (60) days prior to the date written notification is received by the Council. (B) Refunds for over deductions due to administrator error. Refunds for over deductions due to administrator error of the agency shall be made at 100%.**

**Is the employee participating in Premium Conversion? ☐ Yes or ☐ No**

_____ _____ _____
**Date Benefits Coordinator notified** **Coordinator Signature** **Telephone Number**

**I, the undersigned, do depose and say that the above request for refund of insurance premium is just, correct, and due, according to the regulation stated above.**

**Claimant's signature _____Date: _____**

**For EBC Use Only: Is the employee Eligible for Refund: ☐ Yes or ☐ No**
**Date: _____ EBC Coordinator Signature: _____**