



Office of Management and Enterprise Services  
 Employees Group Insurance Division  
 Request for Insurance Premium Refund

Entity Name: \_\_\_\_\_ Group/Division #: \_\_\_\_\_

Entity Address: \_\_\_\_\_  
 \_\_\_\_\_

Employee Name: \_\_\_\_\_ Member ID or SSN: \_\_\_\_\_

Month/Year	Monthly Premium Paid	Monthly Premium Due	Refund Due
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Total	_____	_____	_____

Reason for overpayment: \_\_\_\_\_  
 \_\_\_\_\_

Insurance Coordinator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Note:** Board Rule 360:10-3-7 (2): Refunds on behalf of employees shall be paid to the entity. In order to receive a refund, the entity must have a credit balance.

**Return completed form to:** Office of Management and Enterprise Services (OMES) Employees Group Insurance Division (EGID), 3545 NW 58<sup>th</sup>, Suite 110, Oklahoma City, OK 73112

EGID USE ONLY

V3 Transaction #: \_\_\_\_\_

Approved for payment: \_\_\_\_\_  
Supervisor Date

Approved for payment: \_\_\_\_\_  
 (If over \$4,000 or six months) Member Accounts Director or Designee Date

**FOR EGID USE ONLY**