



REQUEST FOR APPROVAL OF PAYROLL DEDUCTION STATUS

Pursuant to [62 O.S. § 34.70 \(OSCN 2021\), Oklahoma State Finance Act](#)

Organization name	
U.S. taxpayer identification number (TIN) – also known as federal employer identification number (FEIN)	
Name and title of official contact person(s)	
Mailing address	Phone
	Fax
	Email
Proposed effective date	Website
If applicable, this information will be used when notifying company of any change in Voluntary Payroll Deduction status.	
Name and title of remittance contact person(s)	
Remittance address	Phone
	Fax
	Email
If applicable, this information will be used for remittance of premiums and when contact is required regarding specific employee policy premiums and when billing the 1% or 2% administrative fee for your company's participation in the Voluntary Payroll Deduction Program.	
Check appropriate organization type: <input type="checkbox"/> Credit union with office in Oklahoma <input type="checkbox"/> Bank with office in Oklahoma <input type="checkbox"/> Savings association with office in Oklahoma <input type="checkbox"/> Employee association for dues <input type="checkbox"/> Employee association for contributions to its foundation <input type="checkbox"/> Statewide educational employee organization or association <input type="checkbox"/> Oklahoma Long-Term Care Insurance Partnership Program supplemental insurance (complete Page 2) <input type="checkbox"/> Supplemental insurance or Retirement plan (complete Page 2)	

Check here and leave this section blank if Product Vendor Access contact is the same as:

☐ Official contact ☐ Remittance contact

Supplemental Insurance or Retirement Plan Only	Name of product vendor access contact	
	Mailing address	
	Phone	Email
	Alternate phone	Fax
	This information is required to designate the person to represent your company as the sole contact for purposes of access to state employees.	

I hereby certify that I am authorized by the above-named organization to enter into this contract with the State of Oklahoma. I further certify that I understand for supplemental insurance plans there is a fee of 2% of insurance policy premiums, or 1% of retirement plan contributions, that will be billed monthly.

Signature

Date

Print name and title

SUPPLEMENTAL INSURANCE OR RETIREMENT PLAN(S)

List requested information as registered with the Oklahoma Insurance Department. You may wish to submit supporting documentation reflecting OID approval of the policies/plans listed below. If your intent is to include any policy riders, please include the rider name and rider form number.

*The policy/plan (form) name and number must be exactly as submitted and approved by OID.

[illegible]

(Attach additional sheet if needed.)

Reviewed and approved by _____ Date _____
OID signature