

## BENEFITS MAKE-UP/REFUND FORM

**Make-up**   or    **Refund**

This form is to be used for those situations when Retro Benefits does not generate a payback or refund. A manual make-up or refund will be entered for the current paycheck being processed.

**Note:** If an employee changes plans or coverage (from family to single or single to family) you will need to complete TWO forms; one form to refund the premium for old plan/coverage and one form to makeup the premium for new plan/coverage.

**EMPLOYEE** Provide the requested employee information below:

State of Ohio User ID: _____ NAME: _____
Dept ID: _____ AGENCY NAME: _____

**WHO** If you are requesting a make-up/refund indicate who will receive the make-up/refund:

<input type="checkbox"/> Employee and Agency	or	<input type="checkbox"/> Agency Only	or	<input type="checkbox"/> Employee Only
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**PERIOD & AMOUNT** Provide the requested information on the makeup or refund below.

ppe Date	Benefit Plan Code	Coverage Code	Employee Deduction	Employee COMSUR	Employer Deduction	Employer COMSUR
<b>Total</b>						

**REASON** Indicate the reason for the makeup or refund.

Date/Type of event related to the request (e.g., MAR effective mm/dd/yy) _____
<input type="checkbox"/> New Hire <input type="checkbox"/> Single to Family <input type="checkbox"/> Family to Single <input type="checkbox"/> Part-time status change <input type="checkbox"/> Leave (Disability, Military, Workers' Comp, Personal, Educational, etc.) <input type="checkbox"/> Termination <input type="checkbox"/> Other (Explain)

Your signature below indicates that all benefits enrollment changes within OAKS HCM have been completed and are accurate, necessitating the submission of this form.

Prepared by: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

**Keep a copy of this form for your records. Send the original to HCM Benefits via email or fax at (614) 728-3002.**

<b>DAS USE ONLY</b>	
Approved by: _____	Date: _____
Processed by: _____	Date: _____

## ***INSTRUCTIONS FOR COMPLETING THE BENEFIT MAKE-UPS/REFUNDS FORM***

**Purpose:** The purpose of the Benefits Make-ups/Refunds Form is to record the information needed to request, process, and approve a health care make-up or refund.

**Completing the Form:** All required sections of the form should be completed as follows:

**Make-up or Refund:** Check REFUND or MAKE-UP. You can only process one type of transaction per form. In some instances, you will need to process both a refund and a make-up. For example, an employee changes from single to family coverage. You complete two forms: one form to refund the single premium, and one form to make-up the family premium.

**Employee:** Fill in employee's State of Ohio user id, name, department ID, and agency name.

**Who:** Check whom you are instructing DAS to post a makeup/refund for. In most cases, the makeup/refund will be for the employee and the agency, but if you need to refund just the employee or just the agency you should indicate that in this area.

### **Period & Amount:**

PPE Date: Fill in the pay period end date that the deduction/refund was missed (makeup).

Plan Code: Fill in the plan code for which you are requesting the make-up or refund.  
Choose from the drop-down list.

Employee (Ee) Deduction: Fill in the amount of the employee's make-up or refund.

Employer (Er) Deduction: Fill in the amount of the agency's make-up or refund.

**Reason:** Check the reason for the make-up or refund. If the reason is not listed, check "Other" and describe the reason for the make-up or refund in the space provided.

**Signature:** Sign and date the form. Indicate your phone number, so you can be contacted if necessary.

**Send Form to HCM Benefits:** All forms for make-ups and refunds should be emailed or faxed to HCM Benefits (email is preferable to reduce paper-consumption).

For questions regarding completion of this form or about health make-ups and refunds in general, contact your assigned HCM Benefits Management representative or Melissa Walpole at 614.466.0368.