OKLAHOMA
Office of Management & Enterprise Services

Employees Group Insurance Division

2021 OPTION PERIOD ENROLLMENT/CHANGE FORM

CURRENT EMPLOYEES

THIS FORM MUST BE RETURNED TO YOUR INSURANCE COORDINATOR.

SECTION A: EMPLOYEE INFORMATION (please print)

Group number _____ **Division number** _____ **Group name** _____

Member name _____ **SSN or member ID number** _____
First name **MI** **Last name**

Gender ☐ **Male** ☐ **Female** _____ ☐ **Married** ☐ **Single**
Birth date (MM/DD/YYY)

Mailing address _____ **Phone** _____
☐ **New address**

_____ **Alt Phone** _____
City **State** **ZIP code**

Email address _____

SECTION B: ALL CHANGES ARE EFFECTIVE JAN. 1, 2021.

See back of form for required signatures and enrollment or change to dependent coverage.

Health Plan
Check a box to ADD or CHANGE plans:

☐ No change
☐ Drop all health

☐ BlueLincs HMO
☐ CommunityCare HMO
☐ GlobalHealth HMO
☐ HealthChoice Basic* or Basic Alternative (refer to Option Period materials)
☐ HealthChoice High* or High Alternative (refer to Option Period materials)
***Requires completion of online Tobacco-Free Attestation or reasonable alternative.**
☐ HealthChoice High Deductible Health Plan (HDHP)

Employee primary physician (HMO only) _____ ☐ New patient ☐ Current patient

Dental Plan
Check a box to ADD or CHANGE plans:

☐ No change
☐ Drop all dental

☐ BCBSOK BlueCare Dental High Plan
☐ BCBSOK BlueCare Dental Low Plan
☐ Cigna Prepaid High (K1I09)
☐ Cigna Prepaid Low (OKIV9)
☐ Delta Dental PPO
☐ Delta Dental PPO – Choice
☐ HealthChoice Dental
☐ MetLife High Classic MAC
☐ MetLife Low Classic MAC
☐ Sun Life Preferred Active PPO

Employee primary dentist (prepaid plans only) _____ ☐ New patient ☐ Current patient

Vision Plan
Check a box to ADD or CHANGE plans:

☐ No change
☐ Drop all vision

☐ Primary Vision Care Services (PVCS)
☐ Superior Vision
☐ Vision Care Direct
☐ VSP (Vision Service Plan)

Employee Life Plan

Employee Life CANNOT be added or increased using this form. A separate life insurance application must be completed and approved to add or increase life insurance coverage.

☐ No change ☐ Drop all life insurance
☐ Decrease total life insurance to: $ _____ (keep employee life in $20,000 units)

Dependent Life Plan (Employee Life required)

☐ No change
☐ Drop dependent life
☐ Add or increase to premier option
☐ Add or increase/decrease to standard option
☐ Add or decrease to low option

SECTION C: DEPENDENT COVERAGE

SPOUSE**

Add	Drop					
☐	☐	Health	Name ______________________	SSN ________________		
☐	☐	Dental	Date of birth ______________________	☐ Male	☐ Female	
☐	☐	Vision	Primary physician ______________________	☐ New patient	☐ Current patient	
☐	☐	Dependent Life	Primary dentist ______________________	☐ New patient	☐ Current patient	

**Does your spouse currently have coverage through EGID? ☐ Yes ☐ No (If yes, list name and SSN above.)

CHILD

Add	Drop					
☐	☐	Health	Name ______________________	SSN ________________		
☐	☐	Dental	Date of birth ______________________	☐ Male	☐ Female	
☐	☐	Vision	Primary physician ______________________	☐ New patient	☐ Current patient	
☐	☐	Dependent Life	Primary dentist ______________________	☐ New patient	☐ Current patient	

CHILD

Add	Drop					
☐	☐	Health	Name ______________________	SSN ________________		
☐	☐	Dental	Date of birth ______________________	☐ Male	☐ Female	
☐	☐	Vision	Primary physician ______________________	☐ New patient	☐ Current patient	
☐	☐	Dependent Life	Primary dentist ______________________	☐ New patient	☐ Current patient	

CHILD

Add	Drop					
☐	☐	Health	Name ______________________	SSN ________________		
☐	☐	Dental	Date of birth ______________________	☐ Male	☐ Female	
☐	☐	Vision	Primary physician ______________________	☐ New patient	☐ Current patient	
☐	☐	Dependent Life	Primary dentist ______________________	☐ New patient	☐ Current patient	

PLEASE USE THE DEPENDENT ATTACHMENT FORM TO ADD MORE DEPENDENTS.
(This form is available from your insurance coordinator.)

SECTION D: CERTIFICATION SIGNATURES

Employee name (print) ______________________________

Employee signature ______________________________ **Date** ______________

SPOUSE MUST SIGN IF COMMON-LAW OR EXCLUDED FROM HEALTH AND/OR DENTAL COVERAGE.

☐ **COMMON-LAW SPOUSE CERTIFICATION:** I certify the person listed as my spouse and we have an actual and mutual agreement between ourselves to be married; that this is a permanent relationship, and our relationship is exclusive, as proven by our cohabitation as spouses; and do hereby hold ourselves out publicly as married. **I am aware this relationship can be dissolved only by legal divorce.**

☐ **SPOUSE EXCLUSION CERTIFICATION** (required only if children are covered and spouse is not): I certify I am aware **I am being excluded from health, dental, and/or vision coverage as indicated on this form.** I am also aware an employee who elects to cover all eligible dependent children and NOT their spouse will not have the opportunity to enroll their spouse until either the next annual Option Period or a change of status event occurs.

Spouse signature ______________________________ **Date** ______________