



**Office of Management and Enterprise Services
Employees Group Insurance Division
INSURANCE ENROLLMENT FORM**

EMPLOYER INFORMATION (To be completed by Insurance Coordinator)

Group ID # _____ Division ID # _____ Group Name _____
 New Hire Enrollment Mid-Year Enrollment

EMPLOYEE INFORMATION (Please Print)

SSN or Member ID # _____ Married Single

Employee's Name	First Name	MI	Last Name
Please Print			

Mailing Address _____

City _____ State _____ ZIP Code _____
 Home Telephone # (____) _____ Email Address _____
 Residence State _____ Worksite State _____

Employee's Birth Date	Mo.	Day	Yr.	Sex
				<input type="checkbox"/> M <input type="checkbox"/> F

Effective Date Of Coverage	Mo.	Day	Yr.
		0	1

EMPLOYEE HEALTH PLAN ELECTION

HealthChoice High Basic USA S-Account
 CommunityCare HMO
 GlobalHealth HMO

Employee Primary Physician (HMO Only): _____
 Current Patient New Patient

EMPLOYEE DENTAL PLAN ELECTION

- | | |
|---|--|
| <input type="checkbox"/> Assurant Freedom Preferred | <input type="checkbox"/> HealthChoice Dental |
| <input type="checkbox"/> Assurant Heritage Plus w/SBA (Prepaid) | <input type="checkbox"/> Delta Dental PPO |
| <input type="checkbox"/> Assurant Heritage Secure (Prepaid) | <input type="checkbox"/> Delta Dental PPO - Choice |
| <input type="checkbox"/> CIGNA Dental Care Plan (Prepaid) | <input type="checkbox"/> Delta Dental Premier |

Employee Primary Dentist (Prepaid Only): _____
 Current Patient New Patient

EMPLOYEE VISION PLAN ELECTION

- | | | |
|--|--|--|
| <input type="checkbox"/> Humana/CompBenefits VisionCare Plan | <input type="checkbox"/> Superior Vision Plan | <input type="checkbox"/> Vision Service Plan |
| <input type="checkbox"/> Primary Vision Care Services | <input type="checkbox"/> UnitedHealthcare Vision | |

EMPLOYEE LIFE PLAN ELECTION

Basic and Supplemental Life can be added only during Initial Enrollment, during Option Period, or within thirty days of the loss of other group life insurance (with proof of loss). Supplemental Life Guaranteed Issue (GI) is equal to two times your annual salary rounded up to the next \$20,000 unit. The maximum amount of Supplemental Life you can have in force at any time is \$500,000.

Amounts requested over your GI require a separate Life Insurance Application

Basic Life (required for enrollment in Supplemental Life) \$ 20,000
 Supplemental Life (in \$20,000 units) (If more than GI, a Life Insurance Application is required) \$ _____

Total Employee Life Insurance Requested (Basic and Supplemental) \$ _____

Dependent Life Premier Option (Spouse = \$20,000, Each Child = \$10,000, Birth to 6 months = \$1,000)
 Standard Option (Spouse = \$10,000, Each Child = \$5,000, Birth to 6 months = \$1,000)
 Low Option (Spouse = \$6,000, Each Child = \$3,000, Birth to 6 months = \$1,000)

FOR EGID USE ONLY

HEALTHCHOICE DISABILITY (Available only to certain county employers)

DEPENDENT INFORMATION

SPOUSE* Health Name _____ SSN _____
 Dental Date of Birth _____
 Vision Primary Physician _____ Current Patient New Patient
 Dependent Life Primary Dentist _____ Current Patient New Patient

*Does your Spouse currently have health, dental, and/or vision coverage through EGID? Yes No (If Yes, list Name and SSN above)

CHILD Health Name _____ SSN _____
 Dental Date of Birth _____ Male Female
 Vision Primary Physician _____ Current Patient New Patient
 Dependent Life Primary Dentist _____ Current Patient New Patient

CHILD Health Name _____ SSN _____
 Dental Date of Birth _____ Male Female
 Vision Primary Physician _____ Current Patient New Patient
 Dependent Life Primary Dentist _____ Current Patient New Patient

CHILD Health Name _____ SSN _____
 Dental Date of Birth _____ Male Female
 Vision Primary Physician _____ Current Patient New Patient
 Dependent Life Primary Dentist _____ Current Patient New Patient

PLEASE USE THE DEPENDENT ATTACHMENT FORM TO LIST ADDITIONAL DEPENDENTS

(This form is available from your Insurance Coordinator)

I certify that all selections made on this form are true and in compliance with the Rules of EGID. I agree to deliver documentation that authenticates this statement to the requesting entity upon request.

Employee Signature _____ Date _____

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

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

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

Spouse Signature _____ Date _____

If the member elects the HealthChoice USA plan, I certify that the employee both lives and works outside of Oklahoma and Arkansas and is eligible for enrollment in HealthChoice USA.

I certify that this enrollment is in compliance with the provisions of the employer's Section 125 Plan or, if no 125 Plan is offered, is in compliance with new hire or allowed mid-year coverage enrollments as defined by Title 26, Section 125, of the Internal Revenue Codes (as amended) and pertinent regulations. I further certify that on this date, this employee's annual salary listed below (if required) is correct to the best of my knowledge.

Employee's Annual Salary (Required for Supplemental Life in excess of \$20,000) \$ _____

Insurance Coordinator's Signature _____ Date _____

(Must be signed by Insurance Coordinator to be valid)

PLAN GUIDELINES FOR INSURANCE ENROLLMENT

Please detach and keep for your records

IMPORTANT! YOU MUST READ THE FOLLOWING GUIDELINES BEFORE COMPLETING THIS FORM
Signatures on your form certify that you have read this page and that all of your elections meet the Plan Guidelines.
Refer to Title 74 Oklahoma Statutes §1323, Fraud – Penalties

HealthChoice USA is an option available only to active employees who both live and work outside of Oklahoma and Arkansas. HealthChoice USA offers a nationwide provider network. The premium for HealthChoice USA is higher than the premium for HealthChoice High.

A move or job relocation to a state other than Oklahoma or Arkansas may be considered a Qualifying Event for adding or dropping dental or vision plans. Each employee is subject to their employer's IRC Section 125 rules. For guidance, contact your Insurance Coordinator.

Enrolling yourself and your dependents:

New Hire Enrollments: You can enroll yourself and your dependents in any or all coverage in which your employer participates. Your dependents are not eligible for any coverage in which you are not enrolled. You must make your elections and sign the *Insurance Enrollment Form* within 30 days of your employment date.

Midyear Enrollments: To be eligible for a mid-enrollment after your initial employment (other than Option Period), you must have lost other verifiable group coverage. You can enroll yourself and your dependents only in the specific coverage that you lost. You must make your elections and sign the *Insurance Enrollment Form* or *Insurance Change Form* within 30 days of the qualifying event (the date the loss occurred.)

Supersede Enrollment: You have 30 days following your employment date to make any additions or changes to the coverage you elected. In order to make changes, you must submit a new *Insurance Enrollment Form* with "SUPERSEDE" written across the top. This will alert EGID that no qualifying event is required because the change is being made within 30 days of your employment date. Any changes made to your original coverage are effective the first day of the month following the date you sign the "supersede" form.

Elections:

You must elect health coverage to be eligible for dental and life coverage through EGID. You can exclude health coverage if you have other verifiable group health coverage. You may be asked to provide proof of that coverage. Failure to provide proof when requested will result in termination of all coverage.

Dependent children must be under 26 years of age to be eligible.

If you cover one child, you must cover all of your children. You can elect not to cover dependents who do not reside with you, are married, are not financially dependent on you for support, have other verifiable group coverage, or are eligible for Indian or military benefits. You may be asked to provide proof of that coverage. Failure to provide proof when requested will result in termination of your dependents' coverage.

You can cover your children and exclude your spouse from health and/or dental coverage. If you choose this option, your spouse must sign and date the *Spouse Exclusion Certification* section of this form.

You can cover your children and exclude your spouse from vision and/or life coverage only if your spouse has other verifiable group vision and/or life coverage. You may be asked to provide proof of that coverage. Failure to provide proof when requested will result in termination of all coverage.

Once publicly declared, a common-law relationship can be dissolved only by legal divorce.

You must enroll in Basic Life in order to enroll in Supplemental Life and/or enroll your dependents in Dependent Life.

When you enroll, you will be provided a Confirmation Statement (CS). The CS lists the coverage you are enrolled in, the effective date of your coverage, and the premium amounts. The CS allows you to review your coverage so that any errors can be identified and corrected. **Corrections should be submitted to your Insurance Coordinator or EGID within 60 days of the election.** Corrections reported to your IC or EGID after 60 days will be effective the first of the month following notification.

Notification Time Limits:

The deadlines for submitting this form to EGID are strictly enforced. Forms not received within the specified time periods will not be processed.

New hire enrollment form – must be received by EGID within 40 days of your initial employment date.

Midyear election enrollment form – must be received by EGID within 40 days of the qualifying event.