Office of Management and Enterprise Services
Employees Group Insurance Department
Insurance Change Form

EMPLOYER INFORMATION (To be completed by insurance coordinator) OKCPS Employee#_____

Group ID # 554089 **Division ID #** 0503 **Group Name** OKCPS

EMPLOYEE INFORMATION (Please Print)

SSN or Member ID # _____ ☐ Married ☐ Single

Employee's Name (Please Print)	**First Name**	**M I**	**Last Name**

☐ Legal Name Change From _____ To _____

Mailing Address (if changed)_____
Street

_____
City State ZIP Code

Home Telephone # (____)_____ Email Address_____ Worksite ZIP Code_____

Effective Date of This Change	Mo.		Day		Yr.	
			0	**1**		

EMPLOYEE HEALTH PLAN ELECTION

HealthChoice ☐ High ☐ Basic ☐ USA ☐ High Deductible Health Plan ADD ☐ DROP ☐
☐ Aetna HMO ☐ BlueLincs HMO
☐ CommunityCare HMO ☐ GlobalHealth HMO

Employee Primary Physician (HMO Only) _____ Premium_____
☐ Current Patient ☐ New Patient

EMPLOYEE DENTAL PLAN ELECTION

ADD DROP

☐ Assurant Freedom Preferred ☐ CIGNA Dental Care Plan (Prepaid) ☐ Delta Dental PPO ☐ ☐
☐ Assurant Heritage Plus w/SBA (Prepaid) ☐ Delta Dental PPO - Choice ☐ HealthChoice Dental Plan
☐ Assurant Heritage Secure (Prepaid) ☐ Delta Dental PPO Plus Premier

Employee Primary Dentist (Prepaid Only) _____ Premium_____
☐ Current Patient ☐ New Patient

EMPLOYEE VISION PLAN ELECTION

ADD DROP

☐ Humana Vision Care Plan ☐ Superior Vision ☐ Vision Care Direct ☐ ☐
☐ Primary Vision Care Services ☐ UnitedHealthcare Vision ☐ Vision Service Plan Premium_____

EMPLOYEE LIFE INSURANCE ELECTION

Basic and Supplemental Life can be added only within 30 days of loss of other group life insurance. You can request coverage up to the amount lost, rounded up to the next $20,000 unit. Your request must be accompanied by proof of loss of the other group life coverage that indicates the date of loss and the amount of coverage. A "Life Insurance Application" is not required if coverage is requested within this 30-day period. The maximum amount of Supplemental Life you can have in force at any time is $500,000.

ADD	DROP		
☐	☐	**Basic Life (required for enrollment in Supplemental Life)**	**$ 20,000.00**
☐	☐	**Supplemental Life (indicate the amount you wish to carry in $20,000 units)**	**$**_____
		TOTAL EMPLOYEE LIFE INSURANCE REQUESTED (Basic + Supplemental)	**$**_____

DEPENDENT LIFE ELECTION

ADD	DROP	
☐	☐	Dependent Life Premier Option (Spouse = $20,000, Each Child = $10,000)
☐	☐	Dependent Life Standard Option (Spouse = $10,000, Each Child = $5,000)
☐	☐	Dependent Life Low Option (Spouse = $6,000, Each Child = $3,000)

FOR EGID USE ONLY

DEPENDENT INFORMATION

SPOUSE*

ADD	DROP				
☐	☐	Health	Name ______________________	SSN ______________	
☐	☐	Dental	Date of Birth ____________ Date of Death ____________	☐ Male	☐ Female
☐	☐	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

ADD	DROP				
☐	☐	Health	Name ______________________	SSN ______________	
☐	☐	Dental	Date of Birth ____________ Date of Death ____________	☐ Male	☐ Female
☐	☐	Vision	Primary Physician ______________________	☐ Current Patient	☐ New Patient
☐	☐	Dependent Life	Primary Dentist ______________________	☐ Current Patient	☐ New Patient

CHILD

ADD	DROP				
☐	☐	Health	Name ______________________	SSN ______________	
☐	☐	Dental	Date of Birth ____________ Date of Death ____________	☐ Male	☐ Female
☐	☐	Vision	Primary Physician ______________________	☐ Current Patient	☐ New Patient
☐	☐	Dependent Life	Primary Dentist ______________________	☐ Current Patient	☐ New Patient

CHILD

ADD	DROP				
☐	☐	Health	Name ______________________	SSN ______________	
☐	☐	Dental	Date of Birth ____________ Date of Death ____________	☐ 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 elections made on this form are true and in compliance with the "Plan Guidelines for Election Changes". I agree to deliver documentation that authenticates this statement to the requesting entity.

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 the person listed as my spouse and I have an actual and mutual agreement between ourselves to be married, that this is a permanent relationship, that our relationship is exclusive, as proven by our cohabitation as spouses, and do hereby hold ourselves out publicly as married. **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 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 their spouse until either the next annual Option Period or a change of status event occurs.

Spouse Signature ________________________________ Date ________________

If the employee elects the HealthChoice USA Plan, I certify they both live and work outside of Oklahoma and Arkansas and are eligible for enrollment in HealthChoice USA.

I certify this change 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 midyear coverage changes as defined by Title 26, Section 125, of the Internal Revenue Codes (as amended), and pertinent regulations.

Insurance Coordinator's Signature ____________________________ Date ____________
(Must be signed by insurance coordinator to be valid)

PLAN GUIDELINES FOR ELECTION CHANGES

Please Detach and Retain for Your Records

IMPORTANT! YOU MUST READ THE FOLLOWING PLAN GUIDELINES BEFORE COMPLETING THIS FORM. Signatures on your form certify that you have read this page and that all of your elections meet Plan guidelines. Refer to Title 74 O. S., 2012 § 1323, Penalties for Knowingly Making False Statements.

Changing or adding coverage for yourself and/or your dependents:

Midyear Changes - To be eligible to add, drop or change coverage on yourself and/or your dependents after your initial enrollment (other than Option Period), you must experience a midyear qualifying event. You must make your elections and sign this form within 30 days of the qualifying event.

Strict rules apply to all qualifying events. Benefit changes must be consistent with the qualifying event. Changes must also be necessary or appropriate as a result of the qualifying event, i.e., adding health coverage (a benefit election change) is **NOT** consistent with the loss of a dependent (qualifying event). **Allowable midyear changes within Plan guidelines include:**

- Change in your legal marital status;
- Change in your number of dependents;
- Change in your or your dependent's employment status that directly effects eligibility;
- An event that causes your dependent to satisfy, or cease to satisfy, eligibility requirements (over age limit, etc.);
- Changes in your or your dependent's place of residence that directly effects eligibility or HMO/DMO availability; and
- Leaving on or returning from FMLA leave, leave without pay, USERRA leave, or disability leave.

Changes that do not fall into the above categories are generally not allowed except during Option Period. If you have questions regarding a midyear qualifying event, please contact your insurance coordinator.

If you declined member or dependent life coverage because you had group life coverage through a source other than your participating employer and you later lose that coverage, you can request coverage (up to the amount lost, rounded up to the next $20,000 unit) under the Plan within 30 days of loss of the other group life coverage. Your request must be accompanied by proof of loss of the other group life coverage that indicates the date of loss and the amount of coverage. A "Life Insurance Application" is not required if coverage is requested within this 30-day period. You must be enrolled in Basic Life and have a qualifying event in order to add your dependents to Dependent Life coverage.

HealthChoice USA is an option only for those current 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 and Arkansas may also be considered a qualifying event for adding or dropping dental and/or vision plans. Employees are subject to their employers' IRS Section 125 rules. For guidance, contact your insurance coordinator.

Dropping coverage for yourself or your dependents:

Any coverage that you drop cannot be reinstated for 12 months unless you experience a qualifying event. After 12 months, you can regain coverage if your request is made within 30 days of the end of the 12-month period; however, you may be subject to an orthodontic waiting period.

You must elect health coverage in order to be eligible for dental and/or 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.

To be eligible for coverage, a dependent child must be under the age of 26.

Your dependents are not eligible for any coverage in which you are not enrolled. If you cover one dependent for any benefit, you must cover all of your eligible dependents for that benefit.
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 other coverage. Failure to provide proof when requested will result in termination of all coverage for your covered dependents.

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.

Notification Time Limit - The deadline for submitting this form to EGID is strictly enforced. Forms not received within the specified time period will not be processed. Midyear changes must be received by EGID within 40 days of a qualifying event.

Confirmation Statement – When you make changes to your coverage, you are 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 must be submitted to your insurance coordinator or EGID within 60 days of the election. Corrections reported to your insurance coordinator or EGID after 60 days are effective the first of the month following notification.