Oklahoma City Public Schools

Welcome to OKCPS! We are glad you are here!

Are you taking the Insurance Coverage? Please submit the following within 30 days of your hire date.

- ☐ EGID Insurance Enrollment Form & Beneficiary Designation Form (if electing life insurance through the state)
- ☐ Voya Life and Accidental Death & Dismemberment (AD&D) and Disability Income Insurance Enrollment Form
- ☐ Teachers' Retirement System of Oklahoma Beneficiary Form

Note: If you are adding dependents to any plan, you must submit a birth certificate for your child/children and a marriage certificate for a spouse. If we do not receive this documentation, we will not be able to add your dependents.

All employees who enroll in health coverage will receive the Flexible Benefit Allowance (FBA) in the amount of $707.00 per month ($350.50 per paycheck) to apply toward insurance costs. ***This is not a Flexible Spending Account (FSA).*** In addition, Support and Pro-Tech employees will receive a Board Paid Contribution (BPC) to apply toward insurance costs.

- Support Employees will receive $123.00 per month ($61.50 per paycheck)
- Pro-Tech Employees will receive $155.00 per month ($77.50 per paycheck)

Declining coverage or failure to submit EGID Insurance Enrollment Form within 30 days of your hire date still requires the following forms:

- ☐ Declining Coverage Form with proof of other coverage
- ☐ Voya Life and Accidental Death & Dismemberment (AD&D) and Disability Income Insurance Enrollment Form
- ☐ Teachers' Retirement System of Oklahoma Beneficiary Form

All employees who decline coverage or fail to submit the required forms will receive Cash-in-Lieu. This amount varies based on your position:

- Certified Pro-Tech Employees will receive $69.72 per month ($34.86 per paycheck)
- Support Employees will receive $189.70 per month ($94.85 per paycheck)
- Certified and Non-Certified Pro-Tech BPC $66.68 per month ($33.34 per paycheck)

ALL REQUIRED FORMS MUST BE COMPLETED AND RETURNED WITHIN 30 DAYS OF YOUR HIRE DATE

Email completed forms to: hrbenefits@okcps.org *OR*
Drop Off completed forms to: Clara Luper Center at 615 N. Classen Blvd., Oklahoma City, OK 73106
Monday - Friday 7:30 a.m. - 4:00 p.m.

Oklahoma City Public Schools
P.O. Box 36609, Oklahoma City, OK 73136
Phone: 405-587-0801 | web: www.okcps.org

Oklahoma City
PUBLIC SCHOOLS

Benefits Overview

Welcome to Oklahoma City Public Schools. We offer a comprehensive benefit package under a cafeteria style plan for employees who work at least **20 hours**. Additional information can be found at www.okcps.org/benefits. **Please note that your Benefits Generalist must receive your completed enrollment forms within 30 days of your hire date.**

The following benefits are available to employees and their eligible dependents:

Medical

Six different medical options are offered through the State of Oklahoma (OMES/EGID). As a new employee there are no pre-existing conditions for you or your eligible dependents. Coverage options include three PPO plans (Preferred Provider Organization) and three HMO plans (Health Maintenance Organization).

Plan	Overview	Details
HealthChoice High	For individuals who want the lowest deductible and lowest out-of-pocket cost and still enjoy the benefit of a PPO	• Anything outside of an office visit, the $750 deductible must be met before the plan starts to pay its 80% portion of the services. • The maximum out of pocket per year is $3,300 per individual
HealthChoice Basic	For individuals who want to save on premiums but are willing to take a larger out-of-pocket risk and still enjoy the benefits of a PPO	• Plan pays the first $500 of medical expenses for all covered services. If you don't spend the full $500 in a plan year, then you never pay anything to a provider out-of-pocket. • If you do use the full $500, then you must meet a $1,000 deductible per year before the plan will start to pay 50% of allowed charges. • The maximum out of pocket per year is $4,000 per individual
HealthChoice HDHP	For individuals looking for a qualified High Deductible Health Plan (HDHP) or who want to open a Health Savings Account (HSA)	• Both prescription and medical services must be paid in full by the member until the $1,750 deductible is met • After the deductible is met, the HDHP pays 80% of your covered services and works like HealthChoice High • The maximum out of pocket per year is $6,000 per individual

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	For those individuals who don't want to deal with deductibles and coinsurance and don't mind selecting a Primary Care Physician (PCP), we have three (3) HMO options: Blue Cross Blue Shield of Oklahoma - BlueLincs / Community Care HMO / GlobalHealth HMO ● HMO plans have a copay for each service provided, so you will know the amount owed at the time of service ● HMO plans require that you choose a Primary Care Physician (PCP) that will refer to select specialists. Some plans allow you to self refer for certain care
Dental	Six different dental options are offered through the State of Oklahoma (OMES/EGID). You must select a primary care dentist for yourself and each covered dependent when enrolling in a prepaid dental plan. All plans offer 2 annual cleanings at no cost to you.
Vision	Four different vision plans are offered through the State of Oklahoma (OMES/EGID). All plans offer one annual exam per calendar year. Some of the plans do not send a physical card.
Voya Life Insurance - Employer Paid	OKCPS provides paid term life insurance to you at no cost through VOYA; the amount is based upon your classification: ● $30,000 support personnel (reduces at age 70 to $10,000) ● $35,000 certified personnel ● $50,000 protech, Central Office personnel, Principals
Voya Supplemental Life Insurance	Voya provides supplemental life insurance in increments of $25,000 up to $150,000 without needing a Life Insurance Application. This can be purchased within 30 days of your hire date.You can purchase dependent life for your eligible dependents if you purchase supplemental life for yourself.
Basic and Supplemental Life Insurance (OMES/EGID)	As a new employee, you can purchase life insurance coverage within 30 days of your hire date. You can enroll in Basic Life which is $20,000 and you can enroll in Supplemental Life in units of $20,000 up to your annual salary, rounded up to the nearest $20,000 without an EOI. This is the Guaranteed Issue which is two times your annual salary rounded up to the nearest $20,000. Any amount over $40,000 in Supplemental Life will be age rated as of January 1. You can also purchase Dependent Life for your eligible dependents if you enroll in Basic Life. OMES/EGID offers three tiers of coverage for eligible dependents up to age 26.
Flexible Spending Accounts	The Flexible Spending Accounts (Administered by American Fidelity) allow you to pay for certain non covered medical, dental, vision, hearing and dependent care (day care) expenses on a pre-tax basis. The FSA limit for 2025 is $3,300 and the DSA limit for 2025 is $5,000. The Health Savings Account (administered by American Fidelity) is available for those who enroll in HealthChoice HDHP with a 2025 limit $4,300 for self only or $8,550 for family. **Enrollment in an HSA, DSA or HSA must happen within 30 days of hire.** These plans run with OKCPS fiscal year; July - June

<table>
<tr><td>Teachers Retirement</td><td>
<table>
<tr><td>1 Certified Teachers</td><td>➢ OKCPS contributions 7% of your TRS eligible compensation to your plan.
➢ Automatically enrolled</td></tr>
<tr><td>2 Certified, Pro-Tech and Principal Staff</td><td>➢ OKCPS contributions 7% of your TRS eligible compensation up to $60,000. Once you reach $60,000 during the fiscal year, you will pay 10% of the 7% your eligible contribution to OTRS until the end fiscal year.
➢ Automatically enrolled</td></tr>
<tr><td>3 Support Employees</td><td>➢ OKCPS contributes 90% of the 7% of your annual contribution to OTRS up to $40,000. You will contribution 10% of the 7% of your annual contribution to OTRS. Once your reach $40,000 during the fiscal year, you pay the full 7% employee contribution to OTRS.
➢ Example: For every $1, the district contributes $ .90 cents and you contribute $ .10 cents
➢ You are not automatically enrolled. You must fill out the support TRS election form with 30 days of hire or you will be automatically enrolled.</td></tr>
</table>
</td></tr>
<tr><td>American Fidelity Products</td><td>American Fidelity offers several products including disability, accident, whole life, and other voluntary policies. You would need to contact them within your 30 day new hire period to enroll in their products or transfer your policies from another district. They can be contacted at 405-416-8810 OR by email at AFES-OKCBRANCH@AMERICANFIDELITY.COM</td></tr>
<tr><td>Annuity</td><td>You may also contribute voluntarily to an annuity administered by American Fidelity (405-416-8810) or afes-okcbranch@americanfidelity.com. They offer 403(b), 457(b) plans, IRA or Roth IRA plans. These savings plans can start and stop at any time.</td></tr>
<tr><td>Mutual Fund</td><td>You may also contribute voluntarily to a mutual fund administered by Corebridge (formally Valic) (405-202-0866). They offer 403b, 457b, 401(a) and Roth IRA plans. These savings plans can start and stop at any time.</td></tr>
</table>

NOTE: YOUR BENEFITS GENERALIST MUST RECEIVE YOUR COMPLETED ENROLLMENT FORMS WITHIN 30 DAYS OF YOUR HIRE DATE. FAILURE TO SUBMIT PAPERWORK WILL RESULT IN NO MEDICAL INSURANCE.

Oklahoma City
PUBLIC SCHOOLS

Dependent Documentation Required for Medical, Dental, Vision and Life Insurance Plans

Documentation must be provided within 30 days of Hire or Qualifying Event

Who is an eligible dependent?

Daughter, son, stepdaughter, stepson, foster child, adopted child, child for whom the employee has been granted legal guardianship or child legally placed with the employee for adoption, up to age 26, whether married or unmarried.

A dependent, regardless of age, who is incapable of self-support due to a disability diagnosed prior to age 26. For additional information, contact your Benefits Generalist.

Other unmarried children up to age 26 who live with you and for whom you are primarily responsible. This requires completion and approval of an Application for Coverage for Other Dependent Children. A tax return showing dependency can be provided in lieu of the application.

A spouse can be enrolled in coverage as long as a divorce or legal separation has not been filed. Likewise, a spouse cannot be dropped from coverage while in the process of divorce or legal separation.

What documentation is required?

FOR SPOUSES:

- A copy of your state or county-issued marriage certificate. (PLEASE NOTE: If your marriage certificate is written in a language other than English, you MUST include a copy of an official translation of the document along with a copy of the marriage certificate)

FOR COMMON LAW SPOUSES:

- Completion of Common Law Certification:
  https://oklahoma.gov/content/dam/ok/en/omes/documents/Common-LawSpouseForm.pdf

FOR CHILDREN:

- A copy of the child's birth certificate, naming you as the child's parent, or appropriate court order/adoption decree naming you as the child's legal guardian. (PLEASE NOTE: If your birth certificate is written in a language other than English, you MUST include a copy of an official translation of the document along with a copy of the marriage certificate)

FOR STEPCHILDREN:

- A copy of the child's birth certificate, naming your legal spouse as the child's parent, or appropriate court order/adoption decree naming your spouse as the child's legal guardian.
  AND

- A copy of your state or county-issued marriage certificate. (PLEASE NOTE: If your marriage certificate is written in a language other than English, you MUST include a copy of an official translation of the document along with a copy of the marriage certificate)

*If you are unable to provide any of the documents listed above, you can submit a portion of your latest tax return listing dependents for income tax deduction purposes.

HR

Oklahoma City Public Schools
PO Box 36609, Oklahoma City, OK 73136
Phone: 405-587-0801 | web: okcps.org

Oklahoma City
PUBLIC SCHOOLS

DECLINING HEALTH INSURANCE FORM

EMPLOYEE INFORMATION

Last Name: **First Name:**

SSN: **Hours per Week:** **ID#:** **Hire Date:**

REASON FOR DECLINING COVERAGE:

☐ I am enrolled on my spouse's health insurance plan.

☐ I am enrolled on an individual health plan.

☐ I am not enrolled on any health insurance plan but do not want this coverage.

☐ Other _____

NOTICE: If you are declining Medical Coverage for yourself, your spouse, or your dependents as a new hire you may in the future be able to enroll during Open Enrollment or if a Qualifying Event were to occur.

Qualifying events for Special Enrollment include, termination of employment, reduction of work hours, legal separation, divorce, death, or if COBRA/state mandated continuation of coverage has been exhausted. A change form will need to be turned in the HR office along with documentation of the Qualifying event.

Open Enrollment occurs during the fall each year and gives our employees the opportunity to enroll and/or to change selected group insurance plans

STATEMENT: I have been offered Health Coverage and have elected not to be covered. I understand the Notice above and do not wish to enroll as New Hire at this time. I have read completely the guidelines attached and understand the process. I have asked all questions that I need answered prior to signing this form.

Employee Signature: **Date:**

☐ I plan on enrolling in coverage within my 30 day window. I understand by signing this form that if I do not return my Health Insurance Enrollment form I will not have health coverage and will not be able to enroll unless there is a qualifying event to take place or during Annual Open Enrollment.

OKLAHOMA
Office of Management & Enterprise Services

Employees Group Insurance Division
INSURANCE ENROLLMENT FORM
CURRENT EMPLOYEES

IMPORTANT! Read the Plan Guidelines (Page 3) before completing this form.

Employer information (to be completed by insurance coordinator)

Group ID	Division ID	Group name
554089	0503	Oklahoma City Public Schools

☑ New hire enrollment ☐ Midyear enrollment

Employee information

Name (First MI Last) | SSN

Date of birth | ☐ Male ☐ Female | ☐ Married ☐ Single

Mailing address | City | State | ZIP code

Phone | Alt phone | Email

Effective date of coverage (MM/01/YYYY) | Alt email

Health plan election

- ☐ BCBSOK BlueLincs HMO
- ☐ CommunityCare HMO
- ☐ GlobalHealth HMO
- ☐ HealthChoice High
- ☐ HealthChoice Basic
- ☐ HealthChoice High Deductible Health Plan (HDHP)

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

Dental plan election

- ☐ BCBSOK BlueCare Dental High Plan
- ☐ BCBSOK BlueCare Dental Low Plan
- ☐ Cigna Prepaid High Dental Care Plan
- ☐ Cigna Prepaid Low Dental Care Plan
- ☐ Delta Dental PPO – Choice
- ☐ Delta Dental PPO
- ☐ HealthChoice
- ☐ MetLife High Classic MAC
- ☐ MetLife Low Classic MAC
- ☐ Sun Life Preferred Active PPO

Employee primary dentist (Prepaid only) ☐ Current patient ☐ New patient

Vision plan election

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

Life plan election

Basic and Supplemental Life can be added only during initial enrollment, Option Period, or within 30 days of the loss of other group life insurance (must provide proof). **Guaranteed Issue Supplemental Life** (two times your annual salary rounded to the next $20,000 unit) is only available to new hires. To request more than your GI amount, a life insurance application is required for approval. The maximum amount of Supplemental Life available is $500,000.

☐ Basic Life (required for enrollment in Supplemental Life)	$
☐ Supplemental Life (in $20,000 units)	$
Total Basic and Supplemental Life insurance requested:	$

FOR EGID USE ONLY

Dependent Life
- ☐ Premier Option (spouse = $20,000, each child = $10,000
- ☐ Standard Option (spouse = $10,000, each child = $5,000)
- ☐ Low Option (spouse = $6,000, each child = $3,000)

Disability plan election (available only to certain county employees)

- ☐ HealthChoice Disability

Dependent information

Spouse name		☐ Health ☐ Vision ☐ Dental ☐ Dependent Life
SSN		Primary physician ☐ Current patient ☐ New patient
Date of birth	☐ Male ☐ Female	Primary dentist ☐ Current patient ☐ New patient

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

Child name		☐ Health ☐ Vision ☐ Dental ☐ Dependent Life
SSN		Primary physician ☐ Current patient ☐ New patient
Date of birth	☐ Male ☐ Female	Primary dentist ☐ Current patient ☐ New patient
Child name		☐ Health ☐ Vision ☐ Dental ☐ Dependent Life
SSN		Primary physician ☐ Current patient ☐ New patient
Date of birth	☐ Male ☐ Female	Primary dentist ☐ Current patient ☐ New patient
Child name		☐ Health ☐ Vision ☐ Dental ☐ Dependent Life
SSN		Primary physician ☐ Current patient ☐ New patient
Date of birth	☐ Male ☐ Female	Primary dentist ☐ Current patient ☐ New patient

To list additional dependents, please obtain the Dependent Attachment Form from your insurance coordinator.

Signatures

I certify all selections made on this form are true and in compliance with the Plan Guidelines for Insurance Enrollment. I agree to deliver documentation that authenticates this statement to EGID upon request.

Employee signature	Date

Spouse must sign if common-law or excluded from health, dental and/or vision coverage.

☐ **Common-law spouse certification:** I certify that this person listed above as my spouse and I have an actual and mutual agreement between ourselves to be married; 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 that this relationship can be dissolved only by legal divorce.

☐ **Spouse exclusion certification (only required if children are covered and spouse is not):** I certify that I am aware I am being excluded from health, dental and/or vision 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 the next annua Option Period or when a change of status event occurs.

Spouse signature	Date

I certify 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 midyear coverage enrollments as defined by Title 26, Section 125, of the Internal Revenue Code (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 more than $20,000)	
Insurance coordinator signature	Date

OKLAHOMA
Office of Management
& Enterprise Services

Employees Group Insurance Division
Beneficiary Designation Form

Please read the instructions carefully and complete this form in ink.

SSN or Member ID: _____ Member Name: _____
First MI Last

Address: _____
☐ New Address Street City State ZIP

Phone: (____) _____ Alt Phone: (____) _____

Important*: Please ensure the "Share Percentage" section in both Primary Beneficiary(ies) and Contingent Beneficiary(ies) add up to 100 percent. Payment will be made in equal shares to all surviving beneficiaries unless otherwise indicated.

PRIMARY BENEFICIARY(IES)

Primary Beneficiary's Name and Address	SSN	Phone #	Relationship	Date of Birth	Share Percentage
					100%

CONTINGENT BENEFICIARY(IES)

Proceeds are paid to the contingent beneficiary(ies) identified below only if there is no surviving primary beneficiary(ies).

Contingent Beneficiary's Name and Address	SSN	Phone #	Relationship	Date of Birth	Share Percentage
					100%

I have named the above beneficiary(ies) to receive my life insurance benefits from HealthChoice. I understand this form replaces and cancels all prior beneficiary designations and will become effective only when it is received by EGID.

_____ _____
Member Signature - original signature required Date

Mail this form to OMES EGID at P.O. Box 11137, Oklahoma City, OK 73136-9998

Instructions for Completing the Beneficiary Designation Form

This beneficiary form applies to the HealthChoice Life Insurance Plan offered through the Office of Management and Enterprise Services Employees Group Insurance Division. If you are retired, it does not affect the beneficiaries for any death benefit you may have through your retirement system.

The beneficiary designations you make on this form replace and cancel all prior life insurance beneficiary designations with EGID. Your designations do not become effective until this form is **signed** and **received** by EGID. Do not alter this form or attach additional pages.

It is very important that you provide the **full legal name, address, relationship, date of birth and Social Security number of each beneficiary you designate.** This information is essential in ensuring that your named beneficiaries can be located and receive your intended benefit amount. The Beneficiary Designation Form has three parts: Member Information, Primary and Contingent Beneficiary Designation and Signature. **Please print clearly in ink.**

Employer Name – Provide the name of your employer. This information is not required of a former employee/retiree.

Member Information – Provide your name, SSN or Member ID and address.

Primary Beneficiary Designation – You can designate one or more primary beneficiaries. All primary beneficiaries share equally, unless you note otherwise. In the event that multiple primary beneficiaries are named and a primary beneficiary dies before or simultaneously with you, the remaining primary beneficiary(ies) will be entitled to equal share of the deceased beneficiary's designated benefit amount.

Contingent Beneficiary Designation – You can designate one or more contingent beneficiaries. Contingent beneficiaries receive benefits only in the event all primary beneficiaries die before or simultaneously with you. All contingent beneficiaries share equally, unless you note otherwise on your form. In the event that multiple contingent beneficiaries are named and a contingent beneficiary dies before or simultaneously with you, the remaining contingent beneficiary(ies) will be entitled to equal share of the deceased beneficiary's designated benefit amount.

Signature – You must sign and date your form.

Special Beneficiary Designations

Sometimes members wish to make a special designation for trusts, minors or institutions. If you wish to make a special designation, please read the following information carefully.

Designating a trust as beneficiary – To designate a trust as beneficiary, provide the actual name of the trust and the date the trust was created in the space provided.

Designating a minor as beneficiary – A minor can be named your beneficiary; however, it is often difficult and costly for a minor to receive payment, especially if the amount exceeds $10,000. Before you designate a minor as your beneficiary, you should consult an attorney or professional financial advisor.

Designating an institution as beneficiary – To designate an institution (church, charity, funeral home, etc.) as your beneficiary, provide the full name of the institution and list the address in the space provided.

After you complete and sign the Beneficiary Designation Form, mail it to:

Office of Management and Enterprise Services
Employees Group Insurance Division
P.O. Box 11137, Oklahoma City, OK 73136-9998

Remember to keep a copy of your completed form for your records.

BENEFICIARY DESIGNATION (ACTIVE or NOT RETIRED)-MEMBER ACCOUNT

Member Name _____ Member SSN or TRS Member ID _____

SECTION 1 –MEMBER ACCOUNT: Upon the death of a member who has not retired, the designated beneficiary(ies) shall receive the member's account balance as provided by law.

A. **PRIMARY BENEFICIARY(IES)**: It is very important to clearly indicate your primary beneficiary(ies). Upon the death of any designated primary beneficiary, his/her interest shall pass to the surviving primary beneficiary(ies). If multiple primary beneficiaries are named and no percentage distribution is noted, any proceeds payable to such beneficiaries will be divided equally. Provided, if more than one primary beneficiary is named, the beneficiary shall not have the option to choose Option 2 (joint annuitant) retirement, if applicable, upon the member's death. If you have more than four primary beneficiaries, use a copy of this page to list additional beneficiaries.

I hereby designate:

Name	Date of Birth	SSN	Address	Relationship	Share (must equal 100%)

B. **CONTINGENT BENEFICIARY(IES):** Proceeds are paid to contingent beneficiary(ies) only if there is no surviving primary beneficiary(ies) living at the member's death. If multiple contingent beneficiaries are named and no percentage distribution is noted, any proceeds payable to such beneficiaries will be divided equally. If you have more than four contingent beneficiaries, use a copy of this page to list additional beneficiaries.

I hereby designate:

Name	Date of Birth	SSN	Address	Relationship	Share (must equal 100%)

Revoking Previous Designation of Beneficiary: By making these elections, I hereby revoke all other former designations made by me and expressly reserve the right to make other and further changes at any time I may elect as provided by law. If there is no designated beneficiary living at the time of my death, any amount due me shall be paid as provided by Oklahoma law.

Member's Signature _____ Date _____

The member's signature must appear exactly as the name appears on the top of this form.

Minor Beneficiary: Under Oklahoma law, if a minor child (younger than 18 years of age) is designated as beneficiary, it will be necessary that a guardian be appointed by the court before payment is made.

TRS shall not be responsible for determining the competency of any member to designate/change beneficiaries, except as otherwise provided by Oklahoma law, and shall not be liable for the validity of the beneficiary designation.

BENEFICIARY DESIGNATION (ACTIVE or NOT RETIRED)-DEATH BENEFIT

Member Name _____ Member SSN or TRS Member ID _____

SECTION 2 – DEATH BENEFIT: Upon the death of an active (in-service) member who has not retired, TRS will pay to a beneficiary an $18,000 death benefit as provided by law. The member may designate the same beneficiary(ies) listed in Section 1 or a different beneficiary(ies) to receive the death benefit. Provided, if the beneficiary for the $18,000 death benefit differs from the sole beneficiary of the member's account, no beneficiary shall have the option to choose Option 2 (joint annuitant) retirement, if applicable, in lieu of the death benefit. If no beneficiary is named in Section 2, the death benefit shall be paid to the beneficiary(ies) named in Section 1.

A. PRIMARY BENEFICIARY(IES): It is very important to clearly indicate your primary beneficiary(ies). Upon the death of any designated primary beneficiary, his/her interest shall pass to the surviving primary beneficiary(ies). If multiple primary beneficiaries are named and no percentage distribution is noted, any proceeds payable to such beneficiaries will be divided equally. If you have more than four primary beneficiaries, use a copy of this page to list additional beneficiaries.

I hereby designate:

Name	Date of Birth	SSN	Address	Relationship	Share (must equal 100%)

B. CONTINGENT BENEFICIARY(IES): Proceeds are paid to contingent beneficiary(ies) only if there is no surviving primary beneficiary(ies). Contingent beneficiaries do not share in the amount due if any of the primary beneficiaries are living at the member's death. If multiple contingent beneficiaries are named and no percentage distribution is noted, any proceeds payable to such beneficiaries will be divided equally. If you have more than four contingent beneficiaries, use a copy of this page to list additional beneficiaries.

I hereby designate:

Name	Date of Birth	SSN	Address	Relationship	Share (must equal 100%)

Revoking Previous Designation of Beneficiary: By making these elections, I hereby revoke all other former designations made by me and expressly reserve the right to make other and further changes at any time I may elect as provided by law. If there is no designated beneficiary living at the time of my death, any amount due me shall be paid as provided by Oklahoma law.

Member's Signature _____ Date _____

The member's signature must appear exactly as the name appears on the top of this form.

Minor Beneficiary: Under Oklahoma law, if a minor child (younger than 18 years of age) is designated as beneficiary, it will be necessary that a guardian be appointed by the court before payment is made.

TRS shall not be responsible for determining the competency of any member to designate/change beneficiaries, except as otherwise provided by Oklahoma law, and shall not be liable for the validity of the beneficiary designation.

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) AND DISABILITY INCOME INSURANCE ENROLLMENT
OPEN ENROLLMENT M/D/Y THROUGH M/D/Y

ReliaStar Life Insurance Company, Minneapolis, MN
Telephone: 800-955-7736
A member of the Voya® family of companies

PLAN INFORMATION section to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee. **All** new Life or Disability Income coverage or **any** increases in Life or Disability Income coverage will require evidence of insurability if plan participation requirements are not met. Any references to coverage being obtained without evidence of insurability in the sections below are only applicable if the plan participation requirements are met.

PLAN INFORMATION

Employer/Plan Sponsor Name Oklahoma City Public Schools Effective Date of Coverage or Change _____
Group/Plan Number 706451 Account Number/Location 0001
Class/Occupation _____
Date of Hire _____ Annual Salary $_____ Employment Status: ☐ Active Full-Time ☐ Active Part-Time ☐ Retired

This change is due to *(Check all that apply.)*:

☐ Initial Eligibility Following Hire ☐ Change in Coverage Amount ☐ Late Entrant [1] ☐ Other _____

[1] *A late entrant is an individual who is first enrolling after the initial available opportunity.*

EMPLOYEE INFORMATION

Employee Name *(First, Middle Initial, Last)* _____
Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female
Employee ID Number _____ Work Phone (_____)_____ Home Phone (_____)_____
Address _____ City _____ State _____ ZIP _____

EMPLOYEE LIFE / AD&D INSURANCE

Basic Life / AD&D Insurance Election

☑ Employee Only—Elect Coverage *(Note: Basic Life insurance is employer provided.)*
☐ Waive coverage.

Supplemental Life Insurance

Guaranteed Issue (GI) Limit = $150,000. When you are first eligible for supplemental life coverage, you can elect up to the GI Limit without evidence of insurability. At each annual enrollment, if you have current supplemental life coverage you can elect to increase supplemental life coverage by one plan increment without evidence of insurability. Total supplemental life coverage up to $400,000 is available if you complete an Evidence of Insurability form subject to approval by the insurance company.

Supplemental Life Insurance Election

☐ I currently have supplemental life coverage of: $_____.
☐ I am applying for additional supplemental life coverage of: $_____. *($25,000 increments, not to exceed 5 TIMES MY ANNUAL SALARY)*
☐ Total supplemental life coverage (current plus additional): $_____.
☐ Waive coverage.

BENEFICIARY INFORMATION

(Designate your beneficiary(ies) below. Percentages must total 100%, using whole percentages only. If additional space is required please attach a separate signed and dated document with the same information for each beneficiary.)

	Name *(First, MI, Last)*	DOB	Gender	SSN / TIN	Relationship	%	Beneficiary Type
1			☐M ☐F				☐ Primary ☐ Contingent
	Address			**Phone ( )**			
2			☐M ☐F				☐ Primary ☐ Contingent
	Address			**Phone ( )**			
3			☐M ☐F				☐ Primary ☐ Contingent
	Address			**Phone ( )**			

SPOUSE LIFE INSURANCE *(The use of "spouse" in this form means a person insured as a spouse as described in the certificate of insurance or rider. This may include domestic partners or civil union partners as defined by the plan. Please contact the Employer for more information.)*

When you are initially eligible for Spouse coverage, you can elect up to $20,000 in coverage without evidence of insurability. Total Spouse coverage up to $100,000 is available if Spouse completes an Evidence of Insurability form subject to approval by the insurance company. Spouse coverage is limited to 50% of the employee's coverage amount.

Spouse Name *(First, Middle Initial, Last)* _____ Birth Date _____

Spouse Life Insurance Election

☐ Elect: $_____ *($10,000 increments)*

☐ Waive coverage.

Note: The employee is the beneficiary for any Spouse insurance coverage.

CHILDREN LIFE INSURANCE

When you are initially eligible for Children coverage, you can elect it without evidence of insurability. At all other times, you must complete an Evidence of Insurability form for your children subject to approval by the insurance company. Coverage is limited to 50% of the employee's coverage amount.

Children Life Insurance Election

☐ $10,000 for each eligible child

☐ Waive coverage.

Note: The employee is the beneficiary for any Children insurance coverage.

SPOUSE AND CHILDREN INFORMATION

Enter information below. If additional space is required please attach a separate document.

	Spouse Name *(First, MI, Last)*	DOB	Gender	SSN
			☐M ☐F	
	Address			**Phone ( )**

	Child Name *(First, MI, Last)*	DOB	Gender	SSN
1			☐M ☐F	
	Address			**Phone ( )**
2			☐M ☐F	
	Address			**Phone ( )**
3			☐M ☐F	
	Address			**Phone ( )**

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- I understand my coverage begins on the effective date assigned by ReliaStar Life Insurance Company, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

Employee Signature _____ Date _____

Monthly Premiums for Current Employees
Plan Year Jan. 1-Dec. 31, 2025

OKLAHOMA
Office of Management & Enterprise Services

HEALTH PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Blue Cross Blue Shield of Oklahoma – BlueLincs HMO	$ 642.84	$ 883.80	$ 595.88	$ 1,390.02
CommunityCare HMO	$ 702.72	$ 823.90	$ 386.50	$ 655.88
GlobalHealth HMO	$ 1,035.70	$ 1,528.78	$ 591.44	$ 965.86
HealthChoice High and High Alternative	$ 707.00	$ 828.88	$ 355.62	$ 603.46
HealthChoice Basic and Basic Alternative	$ 564.72	$ 662.72	$ 291.22	$ 492.62
HealthChoice High Deductible Health Plan (HDHP)	$ 492.80	$ 578.68	$ 254.52	$ 429.72

TRICARE SUPPLEMENT	MEMBER	MEMBER + ONE	MEMBER + TWO OR MORE
Selman & Company	$ 65.50	$ 129.50	$ 181.00

DISABILITY (Employee only)	$ 10.36 (Limited city and county participation only)

DENTAL PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
BCBSOK – BlueCare Dental High Plan	$ 37.58	$ 37.58	$ 30.46	$ 77.68
BCBSOK – BlueCare Dental Low Plan	$ 23.84	$ 23.84	$ 20.60	$ 50.40
Cigna Prepaid High (K1I09)	$ 13.56	$ 10.98	$ 8.40	$ 14.44
Cigna Prepaid Low (OKIV9)	$ 10.48	$ 6.80	$ 4.62	$ 10.42
Delta Dental PPO	$ 37.72	$ 37.72	$ 32.82	$ 82.94
Delta Dental PPO – Choice	$ 17.88	$ 40.50	$ 40.80	$ 99.02
HealthChoice Dental	$ 48.58	$ 48.58	$ 39.28	$ 100.74
MetLife High Classic MAC	$ 53.22	$ 53.22	$ 45.60	$ 112.94
MetLife Low Classic MAC	$ 30.20	$ 30.20	$ 25.90	$ 63.74
Sun Life Preferred Active PPO	$ 37.08	$ 36.90	$ 27.70	$ 74.36

VISION PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Primary Vision Care Services (PVCS)	$ 10.40	$ 9.28	$ 9.20	$ 11.50
Superior Vision	$ 7.40	$ 7.34	$ 6.96	$ 14.30
Vision Care Direct	$ 15.48	$ 10.96	$ 10.96	$ 24.48
VSP (Vision Service Plan)	$ 8.62	$ 5.66	$ 5.58	$ 12.22

LIFE	Basic Life ($20,000) $5.20	First $20,000 of Supplemental Life $5.20

SUPPLEMENTAL LIFE – Age-rated cost per additional $20,000 unit			
<30 – $ 1.20	30-34 – $ 1.20	35-39 – $ 1.20	40-44 – $ 1.60
45-49 – $ 2.80	50-54 – $ 5.20	55-59 – $ 8.00	60-64 – $ 9.20
65-69 – $ 14.80	70-74 – $ 25.60	75+ – $ 39.20	

DEPENDENT LIFE	Low Option $2.60	Standard Option $4.32	Premier Option $11.26
Spouse	$ 6,000 of coverage	$ 10,000 of coverage	$ 20,000 of coverage
Child (live birth to age 26)	$ 3,000 of coverage	$ 5,000 of coverage	$ 10,000 of coverage

Dependent Life does not include Accidental Death and Dismemberment (AD&D).

2025 Current Employee Monthly Cumulative Premiums

HEALTH	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Blue Cross Blue Shield of Oklahoma – BlueLincs HMO	$ 642.84	$ 1,526.64	$ 2,122.52	$ 2,916.66	$ 1,238.72	$ 2,032.86
CommunityCare HMO	$ 702.72	$ 1,526.62	$ 1,913.12	$ 2,182.50	$ 1,089.22	$ 1,358.60
GlobalHealth HMO	$ 1,035.70	$ 2,564.48	$ 3,155.92	$ 3,530.34	$ 1,627.14	$ 2,001.56
HealthChoice High and High Alternative	$ 707.00	$ 1,535.88	$ 1,891.50	$ 2,139.34	$ 1,062.62	$ 1,310.46
HealthChoice Basic and Basic Alternative	$ 564.72	$ 1,227.44	$ 1,518.66	$ 1,720.06	$ 855.94	$ 1,057.34
HealthChoice High Deductible Plan (HDHP)	$ 492.80	$ 1,071.48	$ 1,326.00	$ 1,501.20	$ 747.32	$ 922.52
TRICARE Supplement - Selman & Company	$ 65.50	$ 129.50	$ 181.00	$ 181.00	$ 129.50	$ 181.00

DENTAL	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
BCBSOK – BlueCare Dental High Plan	$ 37.58	$ 75.16	$ 105.62	$ 152.84	$ 68.04	$ 115.26
BCBSOK – BlueCare Dental Low Plan	$ 23.84	$ 47.68	$ 68.28	$ 98.08	$ 44.44	$ 74.24
Cigna Prepaid High (K1I09)	$ 13.56	$ 24.54	$ 32.94	$ 38.98	$ 21.96	$ 28.00
Cigna Prepaid Low (OKIV9)	$ 10.48	$ 17.28	$ 21.90	$ 27.70	$ 15.10	$ 20.90
Delta Dental PPO	$ 37.72	$ 75.44	$ 108.26	$ 158.38	$ 70.54	$ 120.66
Delta Dental PPO – Choice	$ 17.88	$ 58.38	$ 99.18	$ 157.40	$ 58.68	$ 116.90
HealthChoice Dental	$ 48.58	$ 97.16	$ 136.44	$ 197.90	$ 87.86	$ 149.32
MetLife High Classic MAC	$ 53.22	$ 106.44	$ 152.04	$ 219.38	$ 98.82	$ 166.16
MetLife Low Classic MAC	$ 30.20	$ 60.40	$ 86.30	$ 124.14	$ 56.10	$ 93.94
Sun Life Preferred Active PPO	$ 37.08	$ 73.98	$ 101.68	$ 148.34	$ 64.78	$ 111.44

VISION	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Primary Vision Care Services (PVCS)	$ 10.40	$ 19.68	$ 28.88	$ 31.18	$ 19.60	$ 21.90
Superior Vision	$ 7.40	$ 14.74	$ 21.70	$ 29.04	$ 14.36	$ 21.70
Vision Care Direct	$ 15.48	$ 26.44	$ 37.40	$ 50.92	$ 26.44	$ 39.96
VSP (Vision Service Plan)	$ 8.62	$ 14.28	$ 19.86	$ 26.50	$ 14.20	$ 20.84

EGID Life Premium Chart for Current Employees

Jan. 1 through Dec. 31, 2025

The coverage levels and monthly premiums listed below include Basic Life.

Amount/Age*	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Basic $ 20,000**	5.20	5.20	5.20	5.20	5.20	5.20	5.20	5.20	5.20	5.20	5.20
$ 40,000	10.40	10.40	10.40	10.40	10.40	10.40	10.40	10.40	10.40	10.40	10.40
$ 60,000	11.60	11.60	11.60	12.00	13.20	15.60	18.40	19.60	25.20	36.00	49.60
$ 80,000	12.80	12.80	12.80	13.60	16.00	20.80	26.40	28.80	40.00	61.60	88.80
$ 100,000	14.00	14.00	14.00	15.20	18.80	26.00	34.40	38.00	54.80	87.20	128.00
$ 120,000	15.20	15.20	15.20	16.80	21.60	31.20	42.40	47.20	69.60	112.80	167.20
$ 140,000	16.40	16.40	16.40	18.40	24.40	36.40	50.40	56.40	84.40	138.40	206.40
$ 160,000	17.60	17.60	17.60	20.00	27.20	41.60	58.40	65.60	99.20	164.00	245.60
$ 180,000	18.80	18.80	18.80	21.60	30.00	46.80	66.40	74.80	114.00	189.60	284.80
$ 200,000	20.00	20.00	20.00	23.20	32.80	52.00	74.40	84.00	128.80	215.20	324.00
$ 220,000	21.20	21.20	21.20	24.80	35.60	57.20	82.40	93.20	143.60	240.80	363.20
$ 240,000	22.40	22.40	22.40	26.40	38.40	62.40	90.40	102.40	158.40	266.40	402.40
$ 260,000	23.60	23.60	23.60	28.00	41.20	67.60	98.40	111.60	173.20	292.00	441.60
$ 280,000	24.80	24.80	24.80	29.60	44.00	72.80	106.40	120.80	188.00	317.60	480.80
$ 300,000	26.00	26.00	26.00	31.20	46.80	78.00	114.40	130.00	202.80	343.20	520.00
$ 320,000	27.20	27.20	27.20	32.80	49.60	83.20	122.40	139.20	217.60	368.80	559.20
$ 340,000	28.40	28.40	28.40	34.40	52.40	88.40	130.40	148.40	232.40	394.40	598.40
$ 360,000	29.60	29.60	29.60	36.00	55.20	93.60	138.40	157.60	247.20	420.00	637.60
$ 380,000	30.80	30.80	30.80	37.60	58.00	98.80	146.40	166.80	262.00	445.60	676.80
$ 400,000	32.00	32.00	32.00	39.20	60.80	104.00	154.40	176.00	276.80	471.20	716.00
$ 420,000	33.20	33.20	33.20	40.80	63.60	109.20	162.40	185.20	291.60	496.80	755.20
$ 440,000	34.40	34.40	34.40	42.40	66.40	114.40	170.40	194.40	306.40	522.40	794.40
$ 460,000	35.60	35.60	35.60	44.00	69.20	119.60	178.40	203.60	321.20	548.00	833.60
$ 480,000	36.80	36.80	36.80	45.60	72.00	124.80	186.40	212.80	336.00	573.60	872.80
$ 500,000	38.00	38.00	38.00	47.20	74.80	130.00	194.40	222.00	350.80	599.20	912.00
$ 520,000	39.20	39.20	39.20	48.80	77.60	135.20	202.40	231.20	365.60	624.80	951.20

*Chart based on member's age as of Jan. 1, 2025.

**Basic Life must be purchased before Supplemental Life coverage is available.

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VOYA Supplemental Life Rates

effective 10/01/2018

VOYA Supplemental Life Insurance

effective 10/1/2018

Employee Monthly Premium Table

		25,000	50,000	75,000	100,000	125,000	150,000	175,000	200,000	225,000	250,000	275,000	300,000	325,000	350,000	375,000	400,000
0 - 24	**0.06**	1.50	3.00	4.50	6.00	7.50	9.00	10.50	12.00	13.50	15.00	16.50	18.00	19.50	21.00	22.50	24.00
25-29	**0.07**	1.75	3.50	5.25	7.00	8.75	10.50	12.25	14.00	15.75	17.50	19.25	21.00	22.75	24.50	26.25	28.00
30-34	**0.08**	2.00	4.00	6.00	8.00	10.00	12.00	14.00	16.00	18.00	20.00	22.00	24.00	26.00	28.00	30.00	32.00
35 - 39	**0.09**	2.25	4.50	6.75	9.00	11.25	13.50	15.75	18.00	20.25	22.50	24.75	27.00	29.25	31.50	33.75	36.00
40 - 44	**0.14**	3.50	7.00	10.50	14.00	17.50	21.00	24.50	28.00	31.50	35.00	38.50	42.00	45.50	49.00	52.50	56.00
45 - 49	**0.22**	5.50	11.00	16.50	22.00	27.50	33.00	38.50	44.00	49.50	55.00	60.50	66.00	71.50	77.00	82.50	88.00
50 - 54	**0.33**	8.25	16.50	24.75	33.00	41.25	49.50	57.75	66.00	74.25	82.50	90.75	99.00	107.25	115.50	123.75	132.00
55 - 59	**0.61**	15.25	30.50	45.75	61.00	76.25	91.50	106.75	122.00	137.25	152.50	167.75	183.00	198.25	213.50	228.75	244.00
60 - 64	**0.66**	16.50	33.00	49.50	66.00	82.50	99.00	115.50	132.00	148.50	165.00	181.50	198.00	214.50	231.00	247.50	264.00
65 - 69	**1.27**	31.75	63.50	95.25	127.00	158.75	190.50	222.25	254.00	285.75	317.50	349.25	381.00	412.75	444.50	476.25	508.00
70 +	**2.06**	51.50	103.00	154.50	206.00	257.50	309.00	360.50	412.00	463.50	515.00	566.50	618.00	669.50	721.00	772.50	824.00

Spouse Monthly Premium Table

		10,000	20,000	30,000	40,000	50,000	60,000	70,000	80,000	90,000	100,000
0 - 24	**0.16**	1.60	3.20	4.80	6.40	8.00	9.60	11.20	12.80	14.40	16.00
25-29	**0.18**	1.80	3.60	5.40	7.20	9.00	10.80	12.60	14.40	16.20	18.00
30-34	**0.2**	2.00	4.00	6.00	8.00	10.00	12.00	14.00	16.00	18.00	20.00
35 - 39	**0.26**	2.60	5.20	7.80	10.40	13.00	15.60	18.20	20.80	23.40	26.00
40 - 44	**0.34**	3.40	6.80	10.20	13.60	17.00	20.40	23.80	27.20	30.60	34.00
45 - 49	**0.54**	5.40	10.80	16.20	21.60	27.00	32.40	37.80	43.20	48.60	54.00
50 - 54	**0.8**	8.00	16.00	24.00	32.00	40.00	48.00	56.00	64.00	72.00	80.00
55 - 59	**1.26**	12.60	25.20	37.80	50.40	63.00	75.60	88.20	100.80	113.40	126.00
60 - 64	**1.28**	12.80	25.60	38.40	51.20	64.00	76.80	89.60	102.40	115.20	128.00
65 - 69	**3.82**	38.20	76.40	114.60	152.80	191.00	229.20	267.40	305.60	343.80	382.00
70 +	**5.98**	59.80	119.60	179.40	239.20	299.00	358.80	418.60	478.40	538.20	598.00

Monthly Premium All Children

$10,000 of Coverage
1.00

ABOUT US

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