Oklahoma State & Education Employees Group Insurance Board

A Division of the Office of State Finance

INSURANCE CHANGE FORM

EMPLOYER INFORMATION (To be completed by Insurance Coordinator)

Group ID # ________________________ **Division ID #** _______________ **Group Name** ______________________________

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 # (___)____________________ E-Mail Address________________________ Worksite ZIP Code___________________

Effective Date Of This Form	Mo.		Day		Yr.	
			0	1		

EMPLOYEE HEALTH PLAN ELECTION

					ADD	DROP
HealthChoice	☐ High	☐ Basic	☐ USA	☐ S-Account		
CommunityCare HMO	☐ Standard	☐ Alternative	☐ WAP (Must Complete Health Risk Assessment)			
GlobalHealth HMO	☐ Standard	☐ Alternative	☐ WAP (Must Complete Health Risk Assessment)		☐	☐
UnitedHealthcare HMO (Formerly PacifiCare)	☐ Standard	☐ Alternative	☐ WAP (Must Complete Health Risk Assessment)			

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

Employee Primary Dentist (Prepaid Only): ______________________________________ Premium:___________

☐ Current Patient ☐ New Patient

EMPLOYEE VISION PLAN ELECTION

			ADD	DROP
☐ Humana/CompBenefits VisionCare Plan	☐ Superior Vision Plan	☐ Vision Service Plan	☐	☐
☐ Primary Vision Care Services	☐ UnitedHealthcare Vision			

Premium:____________

EMPLOYEE LIFE INSURANCE ELECTIONS

Basic and Supplemental Life can only be added within 30 days of loss of other group life insurance. You may 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 ELECTIONS

ADD	**DROP**	
☐	☐	Dependent Life Premier Option (Spouse = $20,000, Each Child = $10,000, Birth to 6 mos = $1,000)
☐	☐	Dependent Life Standard Option (Spouse = $10,000, Each Child = $5,000, Birth to 6 mos = $1,000)
☐	☐	Dependent Life Low Option (Spouse = $6,000, Each Child = $3,000, Birth to 6 mos = $1,000)

FOR OSEEGIB USE ONLY

DEPENDENT INFORMATION

SPOUSE*

ADD **DROP**

☐ ☐ Health Name: ______________________ SSN: ______________

☐ ☐ Dental Date of Birth: ______________________ Date of Death: ______________

☐ ☐ 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 OSEEGIB?** ☐ **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 selections 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 upon request.

Employee Signature: ______________________ **Date:** ______________

SPOUSE MUST SIGN IF SPOUSE IS COMMON-LAW OR EXCLUDED FROM HEALTH 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 only be dissolved 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 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 mid-year 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 the Plan Guidelines.
Refer to Title 74 Oklahoma Statutes §1323, Fraud - Penalties

Changing or adding coverage for yourself and your dependents:

Midyear Changes: To be eligible to add, drop, or change coverage on yourself and/or your dependents after your initial employment (other than Option Period), you must have experienced a 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 election 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 (benefit election change) is NOT consistent with the loss of a dependent child (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
- 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 in doubt as to whether you qualify for a change, please contact your Insurance Coordinator.

If you declined member or dependent life coverage because of having group life coverage through a source other than your participating employer, and you later lose that coverage, you may 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 already be enrolled in at least 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 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 and/or vision plans. Each employee is subject to their employer's IRC Section 125 rules. For guidance, contact your Insurance Coordinator.

Dropping coverage for yourself or your dependents:

Any coverage that is dropped cannot be reinstated for 12 months (unless you experience a qualifying event). After 12 months, you may regain coverage if requested within 30 days of the end of the 12-month period, but you may be subject to an orthodontia waiting period.

You must elect health coverage in order to be eligible for dental and/or life coverage through OSEEGIB. You may 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 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 child for any given benefit, you must cover all of your children 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 the other coverage. Failure to provide proof when requested will result in termination of all coverage of your covered dependents.

You may 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 may 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 only be dissolved by legal divorce.

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

Confirmation Statement – When you make changes to your coverage 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 error can be identified and corrected. Corrections must be submitted to your Insurance Coordinator or OSEEGIB within 60 days of the election. Corrections reported to your IC or OSEEGIB after 60 days will be effective the first of the month following notification.