



Oklahoma State & Education Employees Group Insurance Board

A Division of the Office of State Finance

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 # (____) _____ E-Mail Address _____
Residence State _____ Worksite State _____

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

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

EMPLOYEE HEALTH PLAN ELECTION

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 Standard Alternative WAP (Must Complete Health Risk Assessment)

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

EMPLOYEE DENTAL PLAN ELECTION

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

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

EMPLOYEE VISION PLAN ELECTION

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

EMPLOYEE LIFE PLAN ELECTION

Basic and Supplemental Life can only be added during Initial Enrollment, during Option Period, or within thirty days of loss of other group life insurance (with proof of loss). Supplemental Life Guaranteed Issue (GI) is equal to two times your yearly salary rounded up to the next \$20,000 unit. The maximum amount of Supplemental Life you can have in force at any time is \$500,000.00.

Amounts requested over your GI require a separate Life Insurance Application

Basic Life (required for enrollment in Supplemental Life) \$ 20,000
 Supplemental Life (If more than Guaranteed Issue, requires Life Insurance Application) \$ _____
(in \$20,000 units)
Total Employee Life Insurance Requested (Basic + Supplemental) \$ _____

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

HEALTHCHOICE DISABILITY (Available only to certain county employers)

FOR OSEEGIB USE ONLY

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 OSEEGIB? 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 OSEEGIB. 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 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 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 yearly salary listed below (if required) is correct to the best of my knowledge.

Employee's Yearly 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 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 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 may 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 enrollment after your initial employment (other than Option Period), you must have lost other verifiable group coverage. You may enroll yourself and your dependents only in the specific coverage that was 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 OSEEGIB 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 will be effective the first day of the month following the date you sign the "supersede" form.

Elections:

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

Eligible dependent children must be under 26 years of age.

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 disqualification 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.

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 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.

Notification Time Limits:

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

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

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

Oklahoma State and Education Employees Group Insurance Board (OSEEGIB)

Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

OSEEGIB is a State of Oklahoma governmental agency that is created and governed by Oklahoma law for the purpose of administering health, life, disability, and dental benefits to state, local government, and education employees, and other groups designated by statute, including each of the preceding group's respective retirees.

Oklahoma privacy laws and the federal Health Insurance Portability and Accountability Act (HIPAA) govern privacy matters between OSEEGIB and its participants concerning the privacy of an individual member's health information. Information contained in an OSEEGIB member's file is confidential by law and we at OSEEGIB are committed to protecting the privacy and security of members' information. This notice describes and gives you examples of how OSEEGIB will use and disclose your health information and your rights regarding this information.

OSEEGIB uses and discloses your protected health information (PHI) for payment of services to enable your medical treatment, and for OSEEGIB business operations in the administration of health plans. The health claims you submit, or health claims submitted by providers for your treatment, contain protected health information and are processed for payment and data collection by claims administrators according to contract terms with OSEEGIB. OSEEGIB and its claim administrators use and disclose your PHI for payment responsibilities that include: collecting premiums, determination of medical necessity according to certification procedures, eligibility issues, coordinating benefits with other insurers, producing Explanations of Benefits, subrogation, and claim adjudication. Contract terms with each of its claims administrators state that the claims administrator is a Business Associate as defined in OSEEGIB Rules, with obligations to protect members' information.

Your health information is used and disclosed by OSEEGIB employees and other entities under contract with OSEEGIB according to the "minimum necessary" standard. OSEEGIB or its claims administrators may use and disclose health information for HealthChoice plan operations that include: providing customer service, resolving grievances, conducting activities to improve members' health and reduce costs, case management and coordination of care, premium rate setting activities, law enforcement, public health threats, workers' compensation/disability, national security, and as permitted or required by law.

OSEEGIB provides limited member information to participating plan sponsors for enrollment purposes and premium comparison.

OSEEGIB will ask for your written permission before it uses or discloses your health information for purposes that are not described in this Notice.

You have the right to:

- a) inspect and copy your health information (generally EOBs), with the exception of psychotherapy notes and/or information that requires a court order;
- b) amend and restrict the health information that OSEEGIB discloses about you; however, OSEEGIB is not required to agree to a requested restriction;
- c) request your communications remain confidential with OSEEGIB;
- d) receive a copy of this Notice;
- e) file a complaint if you believe OSEEGIB improperly used or disclosed your information;
- f) request a listing of your protected health information disclosed by OSEEGIB except that, as a health plan, OSEEGIB is not required to account for disclosures for claims payment, OSEEGIB business operations, and disclosures you requested pursuant to your written Authorization; and,
- g) receive a paper copy of this Notice upon request, if you received this Notice electronically.

OSEEGIB reserves the right to change the terms of this Privacy Notice and will provide all interested persons a revised notice either by U.S. Postal Service delivered to the individual's mailing address on file with OSEEGIB, or through electronic communication by posting the revised Privacy Notice on the OSEEGIB website at **www.sib.ok.gov and www.healthchoiceok.com**

If you believe your privacy rights have been violated, call or send a written complaint to the OSEEGIB HIPAA Information Officer at 3545 NW 58th, Suite 110, Oklahoma City, Oklahoma, 73112, 1-405-717-8701, toll-free 1-800-543-6044, TDD 1-405-949-2281, toll-free TDD 1-866-447-0436; the Secretary of the U. S. Department of Health and Human Services (HHS) at the Office of Civil Rights, 1301 Young Street, Suite 1169, Dallas, TX 75202, 1-214-767-4056, or submit an electronic complaint according to directions located on the HHS Office of Civil Rights website.

Complaints to HHS must be filed within 180 days after the date on which you became aware, or should have been aware, of the violation. No retaliation is allowed against the individual filing a complaint.

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