



# Oklahoma State & Education Employees Group Insurance Board

A Division of the Office of State Finance

## APPLICATION FOR RETIREE/VESTED/NON-VEST/DEFER INSURANCE COVERAGE

<b>RETIREMENT SYSTEM</b>	<input type="checkbox"/> <b>OPERS</b>	<input type="checkbox"/> <b>TRS</b>	<input type="checkbox"/> <b>OLERS</b>	<input type="checkbox"/> <b>OTHER</b>
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My Member Status Will Be:  Retiree  Vested  Non-Vest  Defer\*

\* See Defer Instructions on page 3 - Spouse's SSN or Member ID# \_\_\_\_\_

Cancel My Deferment and Reinstate My Retiree/Vest/Non-Vest Insurance Coverage

### MEMBER INFORMATION

SSN or Member ID # \_\_\_\_\_ Member's Birth Date \_\_\_\_\_ Gender  Male  Female

Member's Name \_\_\_\_\_ Employer \_\_\_\_\_  
First M.I. Last

Mailing Address \_\_\_\_\_  
Street City State ZIP Code

Phone # (\_\_\_\_) \_\_\_\_\_ Alt Phone # (\_\_\_\_) \_\_\_\_\_ Email Address \_\_\_\_\_

Last Date of Employee Insurance Coverage	Mo.	Day	Yr.

Vested / Non-Vested Insurance Effective Date	Mo.	Day	Yr.
		0 1	

Retirement Insurance Effective Date	Mo.	Day	Yr.
		0 1	

### MEMBER HEALTH PLAN Add/Keep Drop Defer

Health Plan Name: \_\_\_\_\_  Check if Medicare Eligible (See Note)

Employee Primary Physician (HMO Only): \_\_\_\_\_  
 Current Patient  New Patient

NOTE: If you or your dependents are eligible for Medicare, an additional application must be completed. Please contact HealthChoice Member Services or your HMO to request an application.

### MEMBER DENTAL PLAN Add/Keep Drop Defer

Dental Plan Name: \_\_\_\_\_

Employee Primary Dentist (Prepaid Only): \_\_\_\_\_  
 Current Patient  New Patient

<u>For OSEEGIB Use Only</u>
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### MEMBER VISION PLAN Add/Keep Drop Defer

Vision Plan Name: \_\_\_\_\_

### MEMBER LIFE INSURANCE

You can keep a minimum of \$5,000 up to the total amount of your current life insurance. You cannot enroll in more life insurance than you currently have. You must keep life insurance on yourself to be able to keep life insurance on your dependents. It is important to consider future life insurance needs because increases cannot be made after this election.

\* **Defer** – Life Insurance cannot be deferred and must be carried as a primary retiree/vested member. You can only defer your health, dental, and/or vision.

I elect to keep \$ \_\_\_\_\_ (\$5,000 to \$40,000 in \$5,000 units) of member life insurance at a flat rate per \$1,000 of coverage

I elect to keep \$ \_\_\_\_\_ (amount above \$40,000 in \$5,000 units) of additional life insurance

## DEPENDENT INFORMATION

NOTE: If you or your dependents are eligible for Medicare, an additional application must be completed. Please contact HealthChoice Member Services or your HMO to request an application. You cannot add dependent life if you do not already have it. The dependent life amount must be the same for each child. The amount for your spouse can be different from that of your child(ren).

### Add/Keep Drop

SPOUSE   Health Name: \_\_\_\_\_  Check if Medicare eligible  
  Dental SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
  Vision Primary Physician: \_\_\_\_\_  Current Patient  New Patient  
(HMO Only)  
  Dep Life\* Primary Dentist: \_\_\_\_\_  Current Patient  New Patient  
(Prepaid Only)  
\*I elect to keep \$\_\_\_\_\_ (in \$500 units) of Dependent Life Insurance

Does your spouse have health, dental, and/or vision coverage through OSEEGIB?  Yes  No (If yes, list Name and SSN above)

### Add/Keep Drop

CHILD   Health Name: \_\_\_\_\_  Check if Medicare eligible  
  Dental SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Male  Female  
  Vision Primary Physician: \_\_\_\_\_  Current Patient  New Patient  
(HMO Only)  
  Dep Life\* Primary Dentist: \_\_\_\_\_  Current Patient  New Patient  
(Prepaid Only)  
\*I elect to keep \$\_\_\_\_\_ (in \$500 units) of Dependent Life Insurance

## CERTIFICATION SIGNATURES

- I authorize the Board to deduct the amount of my premiums from my retirement check according to Board Rule 360:10-3-3-5. (You must verify with your retirement system that your retirement check will cover your premiums.)
- I request the Board direct bill me for my monthly premiums at the mailing address on this form.

### **Spouse must sign 1.) if being excluded from health/dental and/or 2.) if a common-law spouse.**

- Spouse Exclusion Certification:** 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 I cannot be added to coverage at a later date except within 30 days of loss of other group coverage. (Needed only if children are covered and spouse is not.)
- 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 Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Required only if children are covered and spouse is not.)

I understand that no coverage, except vision, can be added at a later date.

Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Retirement information can be found at [www.healthchoiceok.com](http://www.healthchoiceok.com)

You can carry health, dental, vision, and life insurance on yourself and your dependents.

The health, dental, and life coverage that you take into retiree/vest status is the only coverage you can have through your retirement years. If you do not keep coverage now, you cannot add it later. Plan changes can be made during the annual Option Period.

If you are insuring one dependent, you must insure all eligible dependents (for any given coverage) unless they are covered by other group insurance, or Indian or military benefits. Children who have Indian or military benefits or other group insurance may be required to show proof of coverage.

Following your retirement, dependents can only be added within 30 days of one of the following events: birth, adoption or guardianship, marriage, or loss of other group insurance.

**\* DEFER** If your spouse has separate coverage through OSEEGIB at the time you terminate employment, you can transfer your individual health, dental, and/or vision coverage to dependent coverage under your spouse's coverage. Your spouse must contact their employer to add you as a dependent. You must elect to transfer coverage within 30 days of your termination of employment. Any 30-day break in coverage voids your eligibility to keep coverage in the future. Life insurance cannot be deferred and must be carried as a primary retiree/vested member. When you are ready to return to retiree/vest status, you must again complete this form and mark the box on page 1 of your form to cancel your deferment.

### THINGS TO CONSIDER AS A RETIREE WHEN YOU BECOME MEDICARE ELIGIBLE

**IMPORTANT:** *If you are under age 65 and eligible for Medicare, you must notify OSEEGIB and provide your Medicare ID# as it appears on your Medicare card. Medicare supplement coverage is effective the date you become eligible for Medicare, or the 1<sup>st</sup> day of the month following notification of your Medicare eligibility, whichever is later.*

When you turn age 65, if you are enrolled in HealthChoice pre-Medicare health coverage, you will be automatically enrolled in the HealthChoice Employer PDP Medicare Supplement High Option with Part D Plan. If you are on an HMO, you can enroll in their Medicare supplement or Medicare Advantage Prescription Drug (MA-PD) plan, if available. You must contact your HMO for more information about enrolling in an MA-PD plan.

**All Medicare supplement plans (except HealthChoice) and all MA-PD plans offered through OSEEGIB require you to have both Medicare Part A and Medicare Part B.**

If you are eligible, and do not enroll in Medicare Part B, there are only two plans available to you: HealthChoice Employer PDP Medicare Supplement With Part D and HealthChoice Medicare Supplement Without Part D. All medical benefits under these Plans are paid as if you are enrolled in both Medicare Parts A and B. If you are not enrolled in Medicare Part B, the Plan will estimate Medicare's benefits and provide supplemental coverage as if Medicare is the primary carrier. This means that HealthChoice pays secondary and you are responsible for the primary share of the claim.

If you didn't sign up for Part B when you first became eligible, your monthly premium amount for Part B may be higher due to a late enrollment penalty. The Part B premium is separate from your HealthChoice premium and it is taken out of your Social Security check.

For information concerning HMO, MA-PD, dental, or vision plans, contact their customer service numbers.

For information regarding HealthChoice plans, contact:

Oklahoma State and Education Employees Group Insurance Board

3545 NW 58<sup>th</sup>, Suite 110, Oklahoma City, OK 73112

1-405-717-8780 or toll-free 1-800-752-9475 TDD users call 1-405-949-2281 or toll-free 1-866-447-0436.

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 identifiable health information. Information contained in an OSEEGIB member's file is confidential by law and we at OSEEGIB are committed to protecting this information.

This notice describes and gives you examples of the permitted ways your health information may be used and disclosed.

OSEEGIB uses and discloses your protected health information for your treatment, payment for services, and 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 Oklahoma law and contractual terms of confidentiality with OSEEGIB. 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 to determine medical necessity for certification of hospital and medical benefits, case management, approval for supplemental life insurance, grievance matters, premium rate setting, required disease management programs, law enforcement, public health threats, workers' compensation / disability, national security and as required by law. 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 has improperly used or disclosed your information; f) request a listing of disclosures except for treatment, payment, business operations, and per your Authorization after April 14, 2003; and, g) receive a paper copy of this Notice upon request if you have 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 electronic communication by posting the revised Privacy Notice on the OSEEGIB website at **[www.sib.ok.gov](http://www.sib.ok.gov) and [www.healthchoiceok.com](http://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.

**Effective: 8/5/05; Revised: 2009**