

Dental Plan No Change Add or Change Dental Plan Drop Dental Plan

To ADD or CHANGE your dental plan, select from the options below:

- | | | |
|---|--|--|
| <input type="checkbox"/> Assurant Freedom Preferred | <input type="checkbox"/> HealthChoice Dental Plan | <input type="checkbox"/> MetLife Classic |
| <input type="checkbox"/> Assurant Heritage Plus w/SBA (Prepaid) | <input type="checkbox"/> Delta Dental PPO | <input type="checkbox"/> MetLife Value MAC |
| <input type="checkbox"/> Assurant Heritage Secure (Prepaid) | <input type="checkbox"/> Delta Dental PPO – Choice | <input type="checkbox"/> MetLife Value PDP |
| <input type="checkbox"/> CIGNA Dental Care Plan (Prepaid) | <input type="checkbox"/> Delta Dental PPO Plus Premier | |

Member Primary Dentist (Prepaid only) _____ New Patient Current Patient

Vision Plan No Change Add or Change Vision Plan Drop Vision Plan

To ADD or CHANGE your vision plan, select from the options below:

- | | |
|---|--|
| <input type="checkbox"/> Primary Vision Care Services | <input type="checkbox"/> Vision Care Direct |
| <input type="checkbox"/> Superior Vision | <input type="checkbox"/> Vision Service Plan |

DEPENDENT CHANGES

SPOUSE

ADD **DROP**

Pre-Medicare OR Medicare

<input type="checkbox"/>	<input type="checkbox"/> Health	Name _____	SSN _____
<input type="checkbox"/>	<input type="checkbox"/> Dental	Date of Birth _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/>	<input type="checkbox"/> Vision	Primary Physician _____	<input type="checkbox"/> New Patient <input type="checkbox"/> Current Patient
		Primary Dentist _____	<input type="checkbox"/> New Patient <input type="checkbox"/> Current Patient

*Does your spouse currently have coverage through OMES EGID? Yes No (If yes, list Name and SSN above)

CHILD

ADD **DROP**

Pre-Medicare OR Medicare

<input type="checkbox"/>	<input type="checkbox"/> Health	Name _____	SSN _____
<input type="checkbox"/>	<input type="checkbox"/> Dental	Date of Birth _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/>	<input type="checkbox"/> Vision	Primary Physician _____	<input type="checkbox"/> New Patient <input type="checkbox"/> Current Patient
		Primary Dentist _____	<input type="checkbox"/> New Patient <input type="checkbox"/> Current Patient

CERTIFICATION SIGNATURE

You must sign this form. Additionally, if you and/or your Medicare eligible dependents are enrolling in or changing to a different Medicare Supplement or MA-PD plan, you/they must obtain and complete a separate enrollment application AND complete and return this Option Period form to OMES EGID.

Member's Signature _____ Date _____

**If making changes, complete and return no later than Dec. 7, 2016, to:
OMES EGID, P.O. Box 58010, OKC, OK 73157-8010**