



**Oklahoma State and Education Employees Group Insurance Board
2011 OPTION PERIOD ENROLLMENT/CHANGE FORM
CURRENT EMPLOYEE**

THIS FORM MUST BE RETURNED TO YOUR INSURANCE COORDINATOR

SECTION A: EMPLOYEE INFORMATION (Please Print)

Group ID# _____ Division ID# _____ Group Name _____

Member Name _____ SSN or Member ID# _____

First Name MI Last Name

Sex Male Female

_____/_____/_____

Married Single

Birth Date

Mailing Address _____

Phone (____) _____ - _____

New Address

Alt Phone (____) _____ - _____

City State ZIP Code

SECTION B: EMPLOYEE COVERAGE TO BE EFFECTIVE 1-1-2011

See back side of form for required signatures and dependent coverage.

Health Plan

To ADD or CHANGE plans,
check a box to the right:

- NO CHANGE
 DROP ALL HEALTH

- | | | | | |
|-------------------|-----------------------------------|--------------------------------------|------------------------------|------------------------------------|
| HealthChoice | <input type="checkbox"/> High | <input type="checkbox"/> Basic | <input type="checkbox"/> USA | <input type="checkbox"/> S-Account |
| CommunityCare HMO | <input type="checkbox"/> Standard | <input type="checkbox"/> Alternative | | |
| GlobalHealth HMO | <input type="checkbox"/> Standard | <input type="checkbox"/> Alternative | | |
| PacifiCare HMO | <input type="checkbox"/> Standard | <input type="checkbox"/> Alternative | | |

Employee Primary Physician
(HMO Plans Only)
 New Patient Current Patient

Dental Plan

To ADD or CHANGE plans,
check a box to the right:

- NO CHANGE
 DROP ALL DENTAL

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

Employee Primary Dentist
(Prepaid Plans Only)
 New Patient Current Patient

Vision Plan

To ADD or CHANGE plans,
check a box to the right:

- NO CHANGE
 DROP ALL VISION

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

Employee Life Plan

Employee life CANNOT be added or increased by more than \$20,000 using this form. A separate Life Insurance Application must be completed to add or increase life by more than \$20,000.

- NO CHANGE DROP all Life Insurance
 ADD or INCREASE Life Insurance \$20,000*

*Employee annual salary: \$ _____
(Required only for a \$20,000 increase in Life Insurance)

- DECREASE total Life Insurance to: \$ _____
(Employee Life Insurance retained in \$20,000 units)

Dependent Life Plan (Employee Life Required)

- NO CHANGE
 DROP Dependent Life
 ADD or INCREASE to PREMIER Option
 ADD or INCREASE/DECREASE to STANDARD Option
 ADD or DECREASE to LOW Option

FOR IC USE ONLY

**FOR OSEEGIB USE
ONLY**

I have made changes on the back of the form for my dependents. Yes No

SECTION C: DEPENDENT COVERAGE

SPOUSE*

Add Drop

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

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

CHILD

Add Drop

<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
<input type="checkbox"/>	<input type="checkbox"/>	Dependent Life	Primary Dentist: _____	<input type="checkbox"/> New Patient <input type="checkbox"/> Current Patient

CHILD

Add Drop

<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
<input type="checkbox"/>	<input type="checkbox"/>	Dependent Life	Primary Dentist: _____	<input type="checkbox"/> New Patient <input type="checkbox"/> Current Patient

CHILD

Add Drop

<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
<input type="checkbox"/>	<input type="checkbox"/>	Dependent Life	Primary Dentist: _____	<input type="checkbox"/> New Patient <input type="checkbox"/> Current Patient

PLEASE USE THE DEPENDENT ATTACHMENT FORM TO ADD MORE DEPENDENTS
(This form is available from your Insurance Coordinator)

SECTION D: CERTIFICATION SIGNATURES

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 his/her 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:** _____

I certify that on this date, the employee's annual salary as listed on Page 1 (if required) is correct to the best of my knowledge. I further certify (if required) the employee is both living and working outside of Oklahoma and Arkansas for more than 90 consecutive days and is eligible for enrollment in HealthChoice USA. (Required only if member is adding \$20,000 unit of Life Insurance and/or is enrolling in the HealthChoice USA plan)

Insurance Coordinator Signature: _____ **Date:** _____