



**Vision Plan**       No Change       Add or Change Vision Plan\*       DROP Vision Plan

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

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

**Member Life Plan**       No Change       Drop all Life Insurance  
 Decrease Life Insurance to \$ \_\_\_\_\_ (Retained in \$5,000 increments)

**DEPENDENT CHANGES**

**SPOUSE**

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Pre-Medicare OR  Medicare

**ADD    DROP**

- N/A     Health  
N/A     Dental  
 Vision  
N/A     Dependent Life

Date of Birth: \_\_\_\_\_

Primary Physician: \_\_\_\_\_  New Patient  Current Patient

Primary Dentist: \_\_\_\_\_  New Patient  Current Patient

Decrease Dependent Life Amount to \$ \_\_\_\_\_ (Retained in \$500 increments)

**CHILD**

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Pre-Medicare OR  Medicare

**ADD    DROP**

- N/A     Health  
N/A     Dental  
 Vision  
N/A     Dependent Life

Date of Birth: \_\_\_\_\_  Male  Female

Primary Physician: \_\_\_\_\_  New Patient  Current Patient

Primary Dentist: \_\_\_\_\_  New Patient  Current Patient

Decrease Dependent Life Amount to \$ \_\_\_\_\_ (Retained in \$500 increments)

**CERTIFICATION SIGNATURES**

**You must sign this form. Additionally, if you are enrolling in or changing to a different PDP or MA-PD plan, you must obtain and complete a separate enrollment application from that plan, as well as complete and return this Option Period form to OSEEGIB (refer to your Option Period guide for contact information).**

**Member Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Spouse must sign if being excluded from health and/or dental coverage.**

**Spouse Exclusion Certification** (Required only if dropping spouse while continuing to cover children):  
I certify that I am aware **I am being excluded from health and/or dental coverage as indicated on this form.**

**Spouse Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## Important Information for Members and Dependents

- **Member Information** – When completing the member information on the first page of the form, you should provide your OSEEGIB Member ID number if you currently participate in the HealthChoice health and/or dental plans. This number can be found on your HealthChoice ID card. You may provide your Social Security Number if you do not participate in the HealthChoice health and/or dental plan, or you cannot locate your Member ID Number.
- **ATTENTION Medicare Enrollees** – if you are enrolling in or changing to a different PDP or MA-PD plan, you must obtain and complete a separate enrollment application from that plan, as well as complete and return this Option Period form. Refer to your Option Period guide for contact information for each plan.
- **ATTENTION current Aetna members (Pre-Medicare)** – Aetna is not a participating HMO for Plan Year 2011. If you are currently enrolled in Aetna Standard or Alternative Plan, you must choose another health plan.
- **ATTENTION current CommunityCare members (Pre-Medicare)** – CommunityCare has restructured their provider network in the Oklahoma City area. Please verify your provider still participates in CommunityCare's network.
- **ATTENTION current Delta Dental members** – Delta Dental is not offering the Delta Dental PPO - Point of Service plan for 2011. If you are currently enrolled in this plan, **you must choose another dental plan for 2011.**
- **CAUTION:** If you drop your health and/or dental coverage and either drop or reduce your life insurance coverage, you will not be able to regain this coverage in the future. If you drop coverage (except vision) on your dependent(s), you will not be able to regain that coverage in the future unless that dependent loses other group coverage.
- **Confirmation Statement** – If you make any changes to your benefits, a Confirmation Statement will be mailed to you reflecting the benefits you will have on January 1, 2011.
- **HealthChoice USA (Pre-Medicare)** – To be eligible for HealthChoice USA, you must live outside of Oklahoma and Arkansas for more than 90 consecutive days. HealthChoice USA offers a nationwide provider network. The premium for HealthChoice USA is higher than the premium for HealthChoice High. If you return to either of these two states, you have 30 days to change to one of the other plans offered through OSEEGIB. The effective date of the change will be the first of the month following your notification to OSEEGIB.
- **HealthChoice S-Account (Pre-Medicare)** – If you enroll in this plan, you must have a Health Savings Account at a bank or other financial institution and provide proof of that account to OSEEGIB. This proof must be submitted to OSEEGIB by December 15, 2010. If you do not provide the necessary documentation by this time, you will be removed from the HealthChoice S-Account Plan and enrolled in the HealthChoice Basic Plan for the plan year beginning January 1, 2011.
- **Dependent Life** – If you are decreasing dependent life, please fill in the dependent's name and the amount you wish to keep in the space provided. The amount elected must be the same for each dependent child. The amount on your spouse can be different from that of your child(ren).
- **Signatures** - You must sign your form. OSEEGIB cannot process a form without your signature. Your spouse must sign the form if s/he is being dropped from health and/or dental and you are continuing to cover dependent children on these benefits.