

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

SECTION A: EMPLOYEE INFORMATION	SECTION B: IF YOU DO NOT MAKE CHANGES, YOUR 1-1-2011 BENEFITS ARE SHOWN BELOW.																														
<p>ATTICUS FINCH MACOMB COUNTY COURTHOUSE 123 E ALABAMA ST MACOMB GA 99999-9999</p> <p>Entity: MACOMB COUNTY Member ID: 99999999 Birth Date: 9/7/1941 Phone: (555) 555-1234 Alt Phone: (555) 555-2345 Marital Status: SINGLE</p>	<p>Vision Humana/CompBenefits VisionCare Plan Health HealthChoice High Dental HealthChoice Life \$280,000</p> <table border="1" style="width:100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th></th> <th></th> <th>HEA</th> <th>DEN</th> <th>VIS</th> <th>LIFE</th> </tr> </thead> <tbody> <tr> <td>ALEXANDRIA</td> <td>1/2/1945</td> <td>X</td> <td>X</td> <td>X</td> <td>\$20,000</td> </tr> <tr> <td>JEAN L</td> <td>2/4/1962</td> <td>X</td> <td>X</td> <td>X</td> <td>\$10,000</td> </tr> <tr> <td>JEREMY A</td> <td>1/3/1961</td> <td>X</td> <td>X</td> <td>X</td> <td>\$10,000</td> </tr> <tr> <td>CHARLES B</td> <td>6/5/1963</td> <td>X</td> <td>X</td> <td>X</td> <td>\$10,000</td> </tr> </tbody> </table>			HEA	DEN	VIS	LIFE	ALEXANDRIA	1/2/1945	X	X	X	\$20,000	JEAN L	2/4/1962	X	X	X	\$10,000	JEREMY A	1/3/1961	X	X	X	\$10,000	CHARLES B	6/5/1963	X	X	X	\$10,000
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SECTION C: EMPLOYEE CHANGES TO BE EFFECTIVE 1-1-2011
See back side of form for required signatures and dependent changes.

<p>Health Plan</p> <p>To ADD or CHANGE plans, check a box to the right.</p> <p><input type="checkbox"/> No Change <input type="checkbox"/> Drop All Health</p>	<p>HealthChoice <input type="checkbox"/> High <input type="checkbox"/> Basic <input type="checkbox"/> USA <input type="checkbox"/> S-Account</p> <p>CommunityCare HMO <input type="checkbox"/> Standard <input type="checkbox"/> Alternative</p> <p>GlobalHealth HMO <input type="checkbox"/> Standard <input type="checkbox"/> Alternative</p> <p>PacifiCare HMO <input type="checkbox"/> Standard <input type="checkbox"/> Alternative</p>	<p align="center">Employee Primary Physician (HMO Plans Only)</p> <p><input type="checkbox"/> New Patient <input type="checkbox"/> Current Patient</p>
<p>Dental Plan</p> <p>To ADD or CHANGE plans, check a box to the right.</p> <p><input type="checkbox"/> No Change <input type="checkbox"/> Drop All Dental</p>	<p><input type="checkbox"/> Assurant Freedom Preferred <input type="checkbox"/> Assurant Heritage Plus w/SBA (Prepaid) <input type="checkbox"/> Assurant Heritage Secure (Prepaid) <input type="checkbox"/> CIGNA Dental Care Plan (Prepaid) <input type="checkbox"/> Delta Dental PPO <input type="checkbox"/> Delta Dental PPO Choice <input type="checkbox"/> Delta Dental Premier <input type="checkbox"/> HealthChoice</p>	<p align="center">Employee Primary Dentist (Prepaid Plans Only)</p> <p><input type="checkbox"/> New Patient <input type="checkbox"/> Current Patient</p>
<p>Vision Plan</p> <p>To ADD or CHANGE plans, check a box to the right.</p> <p><input type="checkbox"/> No Change <input type="checkbox"/> Drop All Vision</p>	<p><input type="checkbox"/> Humana/CompBenefits VisionCare Plan <input type="checkbox"/> Primary Vision Care Services <input type="checkbox"/> Superior Vision Plan <input type="checkbox"/> UnitedHealthcare Vision <input type="checkbox"/> Vision Service Plan</p>	
<p>Employee Life Plan</p> <p>Employee life CANNOT be added or increased by more than \$20,000 using this form. A Life Insurance Application must be completed to add or increase life by more than \$20,000.</p> <p><input type="checkbox"/> No Change <input type="checkbox"/> Drop All Life Insurance</p> <p><input type="checkbox"/> Add or Increase Life Insurance \$20,000*</p> <p>*Employee annual salary: \$ _____ (Required only for a \$20,000 increase in Life Insurance)</p> <p><input type="checkbox"/> Decrease Life Insurance To: \$ _____ (Employee life insurance retained in \$20,000 increments)</p>	<p>Dependent Life Plan (Employee Life Insurance Required)</p> <p><input type="checkbox"/> No Change <input type="checkbox"/> Drop Dependent Life <input type="checkbox"/> Add or Increase to Premier Option <input type="checkbox"/> Add or Increase/Decrease to Standard Option <input type="checkbox"/> Add or Decrease to Low Option</p>	
	<p>FOR IC USE ONLY</p>	<p>FOR OSEEGIB USE ONLY</p>

TEST_PULL 1 I have made changes on the back of the form for my dependents. Yes No

SECTION D: DEPENDENT CHANGES

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 E: 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:** _____