



**Oklahoma State and Education Employees Group Insurance Board  
2010 OPTION PERIOD ENROLLMENT/CHANGE FORM  
CURRENT EMPLOYEE**

**SECTION A: EMPLOYEE INFORMATION**

**SECTION B: IF YOU DO NOT MAKE CHANGES, YOUR  
1-1-2010 BENEFITS ARE SHOWN BELOW.**

██████████  
██████████  
██████ OK ██████

Health HealthChoice High  
Dental HealthChoice  
Vision Vision Service Plan

HEA DEN VIS LIFE  
X

Entity: █████ PUBLIC SCHOOLS  
Member ID: █████  
Birth Date: █████  
Phone: █████  
Alt Phone: █████  
Marital Status: MARRIED

**SECTION C: EMPLOYEE CHANGES TO BE EFFECTIVE 1-1-2010**  
See back side of form for dependent changes and signatures.

**Health Plan**

- HealthChoice High
- Aetna HMO
- CommunityCare HMO
- GlobalHealth HMO
- PacifiCare HMO
- High
- Standard
- Standard
- Standard
- Standard
- Basic
- Alternative
- Alternative
- Alternative
- Alternative
- USA
- S-Account

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

- No Change
- Drop All Health

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

**Dental Plan**

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

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

- No Change
- Drop All Dental

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

**Vision Plan**

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

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

- No Change
- Drop All Vision

**Employee Life Plan**

Employee life CANNOT be added or increased more than \$20,000 using this form. A 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
- Decrease Life Insurance To \$ \_\_\_\_\_  
(Employee life insurance retained in \$20,000 increments)

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

**Dependent Life Plan: (Employee Life Insurance 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**

**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 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:** 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. (Required only if children are covered and spouse is not.)

**Spouse's 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:** \_\_\_\_\_