OKLAHOMA
Office of Management & Enterprise Services

Employees Group Insurance Division

INSURANCE CHANGE FORM

CURRENT EMPLOYEES

EMPLOYER INFORMATION (To be completed by insurance coordinator)

Group number_____ **Division number**_____ **Group name**_____

EMPLOYEE INFORMATION (Please print)

SSN or Member ID_____ ☐ Married ☐ Single

Employee name (Please print)	**First name**	**MI**	**Last name**

☐ Legal name change From _____ To _____

Mailing address _____

_____
City State ZIP code

Primary telephone_____ Email address_____

Effective date of coverage	Mo.	Day	Yr.
		0 1	

EMPLOYEE HEALTH PLAN ELECTION

		ADD	DROP	NO CHANGE
☐ CommunityCare HMO	☐ HealthChoice High	☐	☐	☐
☐ GlobalHealth HMO	☐ HealthChoice Basic			
☐ HealthChoice High Deductible Health Plan (HDHP)				

Employee primary physician (HMO only)_____ ☐ Current patient ☐ New patient

EMPLOYEE DENTAL PLAN ELECTION

		ADD	DROP	NO CHANGE
☐ BCBSOK BlueCare Dental High Plan	☐ Delta Dental PPO – Choice	☐	☐	☐
☐ BCBSOK BlueCare Dental Low Plan	☐ HealthChoice Dental Plan			
☐ Cigna Prepaid High (K1I09)	☐ MetLife Low Classic MAC			
☐ Cigna Prepaid Low (OKIV9)	☐ MetLife High Classic MAC			
☐ Delta Dental PPO	☐ Sun Life Preferred Active PPO			

Employee primary dentist (prepaid plan only) _____ ☐ Current patient ☐ New patient

EMPLOYEE VISION PLAN ELECTION

		ADD	DROP	NO CHANGE
☐ Primary Vision Care Services	☐ Vision Care Direct	☐	☐	☐
☐ Superior Vision	☐ Vision Service Plan			

EMPLOYEE LIFE PLAN ELECTION

Basic and Supplemental Life can be added only within 30 days of loss of other group life insurance. You can request coverage up to the amount lost, rounded up to the next $20,000 unit. Your request must be accompanied by proof of loss of the other group life coverage that indicates the date of loss and the amount of coverage. A "Life Insurance Application" is not required if coverage is requested within this 30-day period. The maximum amount of Supplemental Life you can have in force at any time is $500,000.

ADD	DROP	NO CHANGE		
☐	☐	☐	Basic Life (required for enrollment in Supplemental Life)	$_____
☐	☐	☐	Supplemental Life (indicate the amount you wish to carry in $20,000 units)	$_____
			Total Employee Life Insurance Requested	$_____

ADD	DROP	NO CHANGE	
☐	☐	☐	Dependent Life Premier Option (Spouse = $20,000, Each Child = $10,000)
☐	☐	☐	Dependent Life Standard Option (Spouse = $10,000, Each Child = $5,000)
☐	☐	☐	Dependent Life Low Option (Spouse = $6,000, Each Child = $3,000)

FOR EGID USE ONLY

DEPENDENT INFORMATION

SPOUSE*

ADD	DROP				
☐	☐	Health	Name ____________________	SSN ____________	
☐	☐	Dental	Date of birth ____________	Date of death ________	☐ Male ☐ Female
☐	☐	Vision	Primary physician ____________	☐ Current patient	☐ New patient
☐	☐	Dependent Life	Primary dentist ____________	☐ Current patient	☐ New patient

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

CHILD

ADD	DROP				
☐	☐	Health	Name ____________________	SSN ____________	
☐	☐	Dental	Date of birth ____________	Date of death ________	☐ Male ☐ Female
☐	☐	Vision	Primary physician ____________	☐ Current patient	☐ New patient
☐	☐	Dependent Life	Primary dentist ____________	☐ Current patient	☐ New patient

CHILD

ADD	DROP				
☐	☐	Health	Name ____________________	SSN ____________	
☐	☐	Dental	Date of birth ____________	Date of death ________	☐ Male ☐ Female
☐	☐	Vision	Primary physician ____________	☐ Current patient	☐ New patient
☐	☐	Dependent Life	Primary dentist ____________	☐ Current patient	☐ New patient

CHILD

ADD	DROP				
☐	☐	Health	Name ____________________	SSN ____________	
☐	☐	Dental	Date of birth ____________	Date of death ________	☐ Male ☐ Female
☐	☐	Vision	Primary physician ____________	☐ Current patient	☐ New patient
☐	☐	Dependent Life	Primary dentist ____________	☐ Current patient	☐ New patient

PLEASE USE THE DEPENDENT ATTACHMENT FORM TO LIST ADDITIONAL DEPENDENTS
(You can obtain this form from your insurance coordinator)

I certify that all selections made on this form are true and comply with the Plan Guidelines for Election Changes. I agree to deliver documentation that authenticates this statement to the requesting entity.

Employee signature________________________________ **Date**________________

SPOUSE MUST SIGN IF COMMON-LAW OR EXCLUDED FROM HEALTH, DENTAL AND/OR VISION COVERAGE.

☐ **COMMON-LAW SPOUSE CERTIFICATION:** I certify the person listed as my spouse and we have an actual and mutual agreement between ourselves to be married; that this is a permanent relationship, and our relationship is exclusive, as proven by our cohabitation as spouses; and do hereby hold ourselves out publicly as married. **I am aware this relationship can be dissolved only 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, dental, and/or vision coverage as indicated on this form.** I am also aware that an employee who elects to cover all eligible dependent children and **not** their spouse will not have the opportunity to enroll their spouse until either the next annual Option Period or a change of status event occurs.

Spouse signature ________________________________ **Date**________________

I certify this change complies with the provisions of the employer's Section 125 plan or, if no 125 plan is offered, complies with new hire or allowed midyear coverage changes as defined by Title 26, Section 125, of the Internal Revenue Codes (as amended) and pertinent regulations.

Insurance Coordinator signature ________________________ **Date**________________
(Must be signed by insurance coordinator to be valid)

Revised 12/14/2021

PLAN GUIDELINES FOR ELECTION CHANGES

Please Detach and Keep for Your Records

IMPORTANT! YOU MUST READ THE FOLLOWING GUIDELINES BEFORE COMPLETING THIS FORM.
Signatures on your form certify that you have read this page and that all of your elections meet the plan guidelines.
Refer to Title 74 O. S. § 1323, Penalties for Knowingly Making False Statements.

Changing or adding coverage for yourself and/or your dependents

Midyear changes − To be eligible to add, drop or change coverage on yourself and/or your dependents after your initial enrollment (other than Option Period), you must experience a midyear qualifying event. You must make your elections and sign this form within 30 days of the qualifying event.

Strict rules apply to all qualifying events. Benefit changes must be consistent with the qualifying event. Changes must also be necessary or appropriate as a result of the qualifying event, e.g., adding health coverage (a benefit election change) is **not** consistent with the loss of a dependent (qualifying event). **Allowable midyear changes within plan guidelines include:**

- Change in your legal marital status.
- Change in your number of dependents.
- Change in your or your dependent's employment status that directly affects eligibility.
- An event that causes your dependent to satisfy, or cease to satisfy, eligibility requirements (age 26, etc.).
- Changes in your or your dependent's place of residence that directly effects eligibility or HMO/DMO availability.
- Beginning or returning from FMLA leave, leave without pay, USERRA leave or disability leave.

Changes that do not fall into the above categories are generally not allowed except during Option Period. If you have questions regarding a midyear qualifying event, please contact your insurance coordinator.

If you declined member or dependent life coverage because you had group life coverage through a source other than your participating employer and later lose that coverage, you can request coverage (up to the amount lost, rounded up to the next $20,000 unit) under the Plan within 30 days of loss of the other group life coverage. Your request must be accompanied by proof of loss of the other group life coverage that indicates the date of loss and the amount of coverage. A Life Insurance Application is not required if coverage is requested within this 30-day period. You must be enrolled in Basic Life and have a qualifying event in order to add your dependents to dependent life coverage.

Dropping coverage for yourself or your dependents

You must elect health coverage in order to be eligible for dental and/or life coverage through EGID. You can exclude health coverage if you have other verifiable health coverage. You may be asked to provide proof of that coverage. Failure to provide proof upon request will result in termination of all coverage.

To be eligible for coverage, a dependent child must be under the age of 26.

Your dependents are not eligible for any coverage in which you are not enrolled. If you cover one dependent for any benefit, you must cover all of your eligible dependents for that benefit. You can elect not to cover dependents who:

- Do not reside with you.
- Are married.
- Are not financially dependent on you for support.
- Have other verifiable group coverage.
- Are eligible for Indian or military benefits.

You may be asked to provide proof of other coverage. Failure to provide proof when requested will result in termination of all coverage for your covered dependents.

You can cover your children and exclude your spouse from health, dental and/or vision coverage. If you choose this option, your spouse must sign and date the Spouse Exclusion Certification section of this form.

You can cover your children and exclude your spouse from life coverage only if your spouse has other verifiable group life coverage. You may be asked to provide proof of that coverage. Failure to provide proof when requested will result in termination of all coverage.

Once publicly declared, a common-law relationship can be dissolved only by legal divorce.

Notification time limit − The deadline for submitting this form to EGID is strictly enforced. Forms not received within the specified time will not be processed. Midyear changes must be received by EGID within 40 days of a qualifying event.

Confirmation statement − When you make changes to your coverage, you are provided a confirmation statement that lists the coverage you are enrolled in, the effective date of your coverage and the premium amounts. It allows you to review your coverage so that any errors can be identified and corrected. Corrections must be submitted to your insurance coordinator or EGID within 60 days of the election. Corrections reported after 60 days are effective the first of the month following notification.