Office of Management and Enterprise Services
Employees Group Insurance Division
INSURANCE ENROLLMENT FORM

EMPLOYER INFORMATION (To be completed by insurance coordinator)

Group ID # _____ **Division ID #** _____ **Group Name** _____

☐ New Hire Enrollment ☐ Midyear Enrollment

EMPLOYEE INFORMATION (Please print)

SSN # _____ ☐ Married ☐ Single

Employee's Name (Please print)	**First Name**	**M I**	**Last Name**

Mailing Address _____

_____
City State ZIP Code

Primary Telephone # _____ Email Address _____

Residence State _____ Worksite State _____

Employee's Birth Date	Mo.	Day	Yr.	Sex
				☐M ☐F

Effective Date of Coverage	Mo.	Day	Yr.
		0 1	

EMPLOYEE HEALTH PLAN ELECTION

☐ Aetna HMO
☐ BlueLincs HMO
☐ CommunityCare HMO
☐ GlobalHealth HMO
☐ HealthChoice Basic
☐ HealthChoice High Deductible Health Plan (HDHP)
☐ HealthChoice High

Employee Primary Physician (HMO only): _____

☐ Current Patient ☐ New Patient

EMPLOYEE DENTAL PLAN ELECTION

☐ Cigna Dental Care Plan (Prepaid)
☐ Delta Dental PPO
☐ Delta Dental PPO – Choice
☐ HealthChoice Dental Plan
☐ MetLife Low Classic MAC
☐ MetLife High Classic MAC
☐ Sun Life Preferred Active PPO

Employee Primary Dentist (Prepaid only): _____

☐ Current Patient ☐ New Patient

EMPLOYEE VISION PLAN ELECTION

☐ Primary Vision Care Services
☐ Superior Vision
☐ Vision Care Direct
☐ Vision Service Plan

EMPLOYEE LIFE PLAN ELECTION

Basic and Supplemental Life can be added only during initial enrollment, during Option Period, or within 30 days of the loss of other group life insurance (with proof of loss). Guaranteed Issue (GI) Supplemental Life is equal to two times your annual salary rounded up to the next $20,000 unit. The maximum amount of Supplemental Life you can have in force at any time is $500,000.

To request amount above your GI, you must submit a Life Insurance Application for approval.

☐ **Basic Life (required for enrollment in Supplemental Life)** $ 20,000

☐ **Supplemental Life (in $20,000 units)** **$**_____

Total Employee Life Insurance Requested (Basic and Supplemental) **$**_____

Dependent Life
☐ Premier Option (spouse = $20,000, each child = $10,000)
☐ Standard Option (spouse = $10,000, each child = $5,000)
☐ Low Option (spouse = $6,000, each child = $3,000)

FOR EGID USE ONLY

☐ **HEALTHCHOICE DISABILITY** (Available only to certain county employees)

DEPENDENT INFORMATION

SPUSE* ☐ Health — Name ______________ SSN ______________
☐ Dental — Date of Birth ______________ ☐ Male ☐ Female
☐ Vision — Primary Physician ______________ ☐ Current Patient ☐ New Patient
☐ Dependent Life — Primary Dentist ______________ ☐ Current Patient ☐ New Patient

***Does your spouse currently have health, dental and/or vision coverage through EGID?** ☐ **Yes** ☐ **No (If Yes, list name and SSN above)**

CHILD ☐ Health — Name ______________ SSN ______________
☐ Dental — Date of Birth ______________ ☐ Male ☐ Female
☐ Vision — Primary Physician ______________ ☐ Current Patient ☐ New Patient
☐ Dependent Life — Primary Dentist ______________ ☐ Current Patient ☐ New Patient

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CHILD ☐ Health — Name ______________ SSN ______________
☐ Dental — Date of Birth ______________ ☐ Male ☐ Female
☐ Vision — Primary Physician ______________ ☐ Current Patient ☐ New Patient
☐ Dependent Life — Primary Dentist ______________ ☐ Current Patient ☐ New Patient

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CHILD ☐ Health — Name ______________ SSN ______________
☐ Dental — Date of Birth ______________ ☐ 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
(This form is available from your insurance coordinator)

I certify that all selections made on this form are true and in compliance with the Plan Guidelines for Insurance Enrollment. 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 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 married; that this is a permanent relationship, and that our relationship is exclusive, as proven by our cohabitation as spouses; and do hereby hold ourselves out publicly as married. **I am aware that this relationship can be dissolved only by legal divorce.**

☐ **SPOUSE EXCLUSION CERTIFICATION** (required only if children are covered and spouse is not)**:** I certify 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 their spouse will not have the opportunity to enroll their spouse until either the next annual Option Period or a midyear qualifying event occurs.

Spouse Signature ______________________ Date ______________

I certify this enrollment is in compliance with the provisions of the employer's Section 125 Plan or, if no 125 Plan is offered, is in compliance with new hire or allowed midyear coverage enrollments as defined by Title 26, Section 125, of the Internal Revenue Codes (as amended) and pertinent regulations. I further certify that on this date, this employee's annual salary listed below (if required) is correct to the best of my knowledge.

Employee's Annual Salary (Required for Supplemental Life in excess of $20,000) $______________

Insurance Coordinator's Signature ______________________ Date ______________
(Must be signed by insurance coordinator to be valid)

PLAN GUIDELINES FOR INSURANCE ENROLLMENT

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., 2012 § 1323, Penalties for Knowingly Making False Statements

Enrolling yourself and your dependents:

New Hire Enrollment − You can enroll yourself and your dependents in any or all coverage in which your employer participates. Your dependents are not eligible for any coverage in which you are not enrolled. You must make your elections and sign the Insurance Enrollment Form within 30 days of your employment date.

Midyear Enrollments − To be eligible for a midyear enrollment after your initial employment date (other than Option Period), you must have lost other verifiable coverage (some exceptions apply). You can enroll yourself and your dependents only in the specific coverage that you lost. You must make your elections and sign the Insurance Enrollment Form or Insurance Change Form within 30 days of the qualifying event (the date the loss occurred).

Supersede Enrollment − You have 30 days following your employment date to make any additions or changes to the coverage you elected. In order to make changes, you must submit a new Insurance Enrollment Form with *SUPERSEDE* written across the top. This will alert EGID that no qualifying event is required because the change is being made within 30 days of your employment date. Any changes made to your original coverage are effective the first day of the month following the date you sign the *supersede* form.

Elections − You must elect health coverage to be eligible for dental and life coverage through EGID. You can exclude health coverage if you have other verifiable group health coverage. You may be asked to provide proof of that coverage. Failure to provide proof when requested will result in termination of all coverage.

Dependent children must be under 26 years of age to be eligible for enrollment.

If you cover one eligible dependent, you must cover all of your eligible dependents. 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, or 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 your dependents' coverages.

You can cover your children and exclude your spouse from health and/or dental 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 vision and/or life coverage only if your spouse has other verifiable group vision and/or 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.

You must enroll in Basic Life in order to enroll in Supplemental Life and/or enroll your dependents in Dependent Life.

When you enroll, you will be provided a confirmation statement, which lists the coverage you are enrolled in, the effective date of your coverage, and the premium amounts. The CS allows you to review your coverage so that any errors can be identified and corrected. **Corrections should be submitted to your insurance coordinator or EGID within 60 days of the election.** Corrections reported to your insurance coordinator or EGID after 60 days will be effective the first of the month following notification.

Notification Time Limits − The deadlines for submitting this form to EGID are strictly enforced. Forms not received within the specified time periods will not be processed.

New hire enrollment: Your form must be received by EGID within 40 days of your initial employment date.
Midyear election enrollment: Your form must be received by EGID within 40 days of the qualifying event.