Office of Management and Enterprise Services Employees Group Insurance Division
2019 OPTION PERIOD ENROLLMENT/CHANGE FORM
CURRENT EMPLOYEE
THIS FORM MUST BE RETURNED TO YOUR INSURANCE COORDINATOR

SECTION A: EMPLOYEE INFORMATION (Please Print)

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

Member Name _____ **SSN or Member ID#** _____
First Name **MI** **Last Name**

Gender ☐ **Male** ☐ **Female** _____/_____/_____ ☐ **Married** ☐ **Single**
Birth Date

Mailing Address _____ **Phone** _____-_____-_____
☐ **New Address**

_____ **Alt Phone** _____- _____-_____
City **State** **ZIP Code**

Email Address _____

SECTION B: ALL CHANGES ARE EFFECTIVE JAN. 1, 2019
See back of form for required signatures and enrollment or change to dependent coverage.

Health Plan
Check a box to ADD or CHANGE plans:

☐ No Change
☐ Drop All Health

☐ Aetna HMO
☐ BlueLincs HMO
☐ CommunityCare HMO
☐ GlobalHealth HMO
☐ HealthChoice Basic***** or Basic Alternative (refer to Option Period materials)
☐ HealthChoice High***** or High Alternative (refer to Option Period materials)
***Requires completion of tobacco-free attestation or reasonable alternative.**
☐ HealthChoice High Deductible Health Plan (HDHP)

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

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Dental Plan

Check a box to ADD or CHANGE plans:

☐ No Change
☐ Drop All Dental

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

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

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Vision Plan
Check a box to ADD or CHANGE plans:

☐ No Change
☐ Drop All Vision

☐ Primary Vision Care Services (PVCS)
☐ Superior Vision
☐ Vision Care Direct
☐ VSP (Vison Service Plan)

Employee Life Plan

Employee life CANNOT be added or increased using this form. A separate Life Insurance Application must be completed and approved to add or increase life insurance coverage.

☐ No Change ☐ Drop All Life Insurance

☐ Decrease Total Life Insurance to: $ _____
(Keep employee life in $20,000 units)

☐ ***I have added or made changes on the back of this form for my dependents.**

Dependent Life Plan (Employee Life 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 EGID USE ONLY**

Revised 08/21/2018

SECTION C: DEPENDENT COVERAGE

SPOUSE*

Add	Drop	Coverage		
☐	☐	Health	Name ______________________	SSN ______________________
☐	☐	Dental	Date of Birth ______________________	☐ Male ☐ Female
☐	☐	Vision	Primary Physician ______________________	☐ New Patient ☐ Current Patient
☐	☐	Dependent Life	Primary Dentist ______________________	☐ New Patient ☐ Current Patient

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

CHILD

Add	Drop	Coverage		
☐	☐	Health	Name ______________________	SSN ______________________
☐	☐	Dental	Date of Birth ______________________	☐ Male ☐ Female
☐	☐	Vision	Primary Physician ______________________	☐ New Patient ☐ Current Patient
☐	☐	Dependent Life	Primary Dentist ______________________	☐ New Patient ☐ Current Patient

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CHILD

Add	Drop	Coverage		
☐	☐	Health	Name ______________________	SSN ______________________
☐	☐	Dental	Date of Birth ______________________	☐ Male ☐ Female
☐	☐	Vision	Primary Physician ______________________	☐ New Patient ☐ Current Patient
☐	☐	Dependent Life	Primary Dentist ______________________	☐ New Patient ☐ Current Patient

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CHILD

Add	Drop	Coverage		
☐	☐	Health	Name ______________________	SSN ______________________
☐	☐	Dental	Date of Birth ______________________	☐ Male ☐ Female
☐	☐	Vision	Primary Physician ______________________	☐ New Patient ☐ Current Patient
☐	☐	Dependent Life	Primary Dentist ______________________	☐ New Patient ☐ Current Patient

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PLEASE USE THE DEPENDENT ATTACHMENT FORM TO ADD MORE DEPENDENTS.
(This form is available from your insurance coordinator.)

SECTION D: CERTIFICATION SIGNATURES

Employee Name (Print) ______________________________

Employee Signature ______________________________ Date ______________

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

☐ **COMMON-LAW SPOUSE CERTIFICATION:** I certify 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 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 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 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 ______________