2020 PLANNING FOR YOUR INSURANCE NEEDS AS A FORMER EMPLOYEE

HEALTH | DENTAL | LIFE | VISION

Employees Group Insurance Division

OMES
OFFICE OF MANAGEMENT & ENTERPRISE SERVICES
This guide is designed to help lead you through the steps to continue your insurance when you leave active employment. This guide will explain which included forms you must complete.

Your Member Status

When you leave active employment, you are given a member status based on your vesting right with a state funded retirement system or your years of employment service. There are four member status categories:

- **Vested** – You have worked long enough to keep insurance benefits and you contributed to a retirement system, but you are not ready to draw your retirement benefits.
- **Non-Vested** – You have worked long enough to keep insurance benefits, but you did not contribute to a retirement system that participates with the Employees Group Insurance Division (EGID), or you withdrew your contributions from your retirement system.
- **Retiree** – You have worked long enough to leave active employment, keep insurance benefits and draw your retirement benefits.
- **Defer** – You have worked long enough to qualify as a vested, non-vested or retiree member, but you elect to transfer your health, dental or vision insurance to your spouse's current insurance through EGID.

If you leave active employment, lose coverage because of reduced employment hours or your employment is terminated for reasons other than gross misconduct, you can continue health, dental and vision coverage for up to 18 months under the Consolidated Omnibus Budget Reconciliation Act.

Coverage continued under COBRA is temporary. If qualified, you are encouraged to continue coverage under one of the other status options.

Years of Service You Need to Continue Insurance at Retirement

- **Teachers' Retirement System (TRS)** – Ten years of creditable service.
- **Oklahoma Public Employees Retirement System (OPERS)** – Eight years of creditable service.
- **Oklahoma Law Enforcement Retirement System (OLERS)** – Eight years of creditable service.
- **Other or No Retirement System** – Employment years may qualify as creditable service to continue insurance. Contact EGID Member Services for specific information.

Plan Premiums

Refer to the premium rate charts in this guide.

Premium Payment Options

- **Retirement check deduction** – Your monthly premium is automatically deducted from your retirement check.
- **Direct bill** – You are directly billed for your monthly premium, and your premium is due by the 20th of each month.
- **Automatic draft** – Your monthly premium is automatically drafted from your checking account on or around the 20th of each month. To elect this option, select the direct bill option on the Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage (Page A2) and provide EGID an Electronic Fund Transfer Authorization and a voided check. This form is available on the EGID website or by contacting member services.
Once you leave active employment, vision insurance is the only benefit that can be added during the annual Option Period.

**Life Insurance** – You can keep, reduce or drop life coverage you have in place at the time you leave active employment. You must make the election within 30 days of leaving active employment. You cannot add or increase life insurance at retirement. Life insurance cannot be deferred and must be kept in your retirement account.

Life insurance must be kept in $5,000 units. Refer to the premium charts included in this guide.

Life insurance continued at retirement does not include Accidental Death and Dismemberment benefits.

If you continue life insurance coverage when you leave active employment, it is very important to keep your beneficiary information current. If you are unsure of your beneficiary designations, please complete the Beneficiary Designation Form (Page D1). Instructions are on the back of the form.

HealthChoice must pay life benefits to the beneficiaries listed on the most recent beneficiary designation. If there is no signed beneficiary designation, benefits are paid to the estate.

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**Coverage for Your Dependents**

You can add, keep or drop health, dental and vision coverage for your spouse and other eligible dependents at retirement; however, dependent life insurance must be in effect before you leave active employment. Dependent coverage must be with the same carrier as the member.

You can exclude your spouse from health, dental and vision coverage and cover your other eligible dependents. Your spouse must sign the Spouse
Exclusion Certification section of the Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage (Page A2).

If you add or keep coverage for your dependent children, including disabled dependents, you must cover all your eligible dependents up to age 26.

You can exclude dependents from coverage if they have other group coverage or are eligible for Indian Health Services or military health benefits. You can also exclude eligible dependents who do not reside with you, are married or are not financially dependent on you.

After retirement, you cannot add dependents to any coverage except vision, unless one of the following qualifying events occurs:

- Birth of a child.
- Your spouse or eligible dependents lose other group coverage.
- You marry.
- You adopt or gain legal guardianship of a child under age 26.

You must add your spouse and any eligible dependents within 30 days of the qualifying event.

Dependent Life Insurance

You can keep dependent life insurance in effect at retirement but cannot add or increase it later. It must be kept in $500 units and each covered dependent pays a separate, individual premium.

- **For your spouse** – The amount you keep for your spouse can be different from the amount you keep for your covered dependents.
- **For your dependents** – The amount you keep must be the same for each covered dependent.

If You Decide to Work Past Age 65

If you decide to work past age 65, you may contact Social Security to delay your enrollment in Medicare Part B. Your employer insurance will be primary payer while working. Since all insurance offered through EGID is creditable coverage, you will not be assessed a penalty once employer insurance ends.

When You Turn Age 65 After You Leave Active Employment

If you are close to age 65 and are not receiving Social Security benefits, you need to enroll in Medicare Part A and Part B.

To enroll, contact Social Security at least three months before you turn age 65. By enrolling early, you avoid any delay in the start of your Medicare coverage.
The Enrollment Process

If You Are Not Yet Eligible for Medicare

To Continue Your Insurance

You must complete the Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage (Page A1) and return it to EGID.

To Defer (Transfer) Your Coverage to Your Spouse’s Plan:

If your spouse works and is currently enrolled in coverage through EGID, you can transfer your health, dental and vision coverage to your spouse’s coverage as a dependent.

Life insurance cannot be deferred and must be kept in your retirement account.

To transfer your coverage to your spouse’s plan:

• Mark Defer on the Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage (Page A1) and return it to EGID.
• Your spouse must contact their employer to add you to their coverage as a dependent.
• Any retirement system contribution paid toward your health insurance premium will not be paid during the deferral period.

As long as your former employer group continues to participate with EGID, you can transfer your coverage back to your own EGID account at any time by completing the Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage.

If You Are Eligible for Medicare

About Medicare

Medicare is the health insurance program for people age 65 or older, people under age 65 with certain disabilities and those with end-stage renal disease.

• Medicare Part A pays for hospitalization services.
• Medicare Part B pays for doctor and outpatient medical services. Call Social Security for information on your Part B premiums. Refer to Contact Information at the back of this guide.
• Medicare Part D pays for prescription drug coverage. All the plans offered through EGID provide Part D coverage. This means the plans all meet the benefit guidelines set by Medicare for creditable prescription drug coverage.

Your enrollment in Medicare is handled in one of two ways:

• Automatic enrollment (depending on your individual circumstances).
• Application for enrollment. You should apply three months prior to turning 65 to avoid a possible delay in the start of your coverage.

Contact Social Security for more information.
To Continue Your Insurance and Enroll in a Medicare Supplement or MAPD Plan

There are two forms you must complete to continue your health coverage:

- You must also complete the form associated with the plan you are enrolling in – the Application for Medicare Supplement With Prescription Drug Plan or the Application for Medicare Advantage Prescription Drug (MAPD) Plan.

Refer to Page 9 for the available Medicare plans.

To Enroll in a Medicare Supplement Plan

The Medicare supplement plans provide supplemental benefits for Medicare Part A and Part B covered services, as well as Part D prescription drug benefits. The plans pay benefits as if you are enrolled in both Medicare Part A and Part B.

To enroll in a Medicare supplement plan, complete and return the Application for Medicare Supplement With Prescription Drug Plan (Page B1). You must provide your Medicare ID number to coordinate your benefits with Medicare.

To Enroll in a Medicare Advantage Prescription Drug Plan

MAPD plans contract with Medicare to provide benefits for Medicare Part A and Part B covered services, as well as Part D prescription drug benefits.

You must be enrolled in Medicare Part A and Part B to be eligible for enrollment. When you enroll in an MAPD plan, the plan replaces Medicare as your primary insurer.

To be eligible to enroll in an MAPD HMO, you must also live in the plan’s approved ZIP code service area. You can receive services only within the plan’s network.

To be eligible to enroll in an MAPD PPO, you may live anywhere in the United States. You can receive services anywhere in the U.S. as long as the provider is a Medicare eligible provider and accepts the plan’s payment terms and conditions.

To enroll in an MAPD plan, you must complete and return the Application for Medicare Advantage Prescription Drug (MAPD) Plan (Page C1). Fill in your Medicare ID number.

Enrollment Deadline

If You Are Not Eligible for Medicare

EGID Administrative Rules allows 30 days from the day your active insurance ends to elect to begin or continue your insurance.

Failure to add, keep or defer coverage within 30 days of your active coverage ending cancels eligibility in the plans offered through EGID.

If You Are Eligible for Medicare

It is important that your application is received at least 30 days prior to the day you leave active employment. This gives EGID enough time to process applications and resolve problems before coverage is effective. It also prevents delays in enrolling in a Part D prescription drug plan.

If your application is not received prior to your employment termination, you may be enrolled in a HealthChoice Medicare supplement plan that includes creditable prescription drug benefits, but not Part D prescription drug benefits, until the first of the following month. This is so you do not experience a break in prescription drug coverage and become subject to a late enrollment penalty. Be aware the premium for this temporary plan is higher.
Plan ID Cards

If you enroll in a Medicare plan through EGID, a new ID card will be issued. Do not destroy your current cards until you receive your new ones.

If You Move Outside Your Plan’s Service Area

If You Are Not Eligible for Medicare

If you are enrolled in an HMO plan and move outside your plan's ZIP code service area, you must notify EGID in writing of your new address. To continue your health coverage, you will need to select a new plan that is in your service area.

If You Are Eligible for Medicare

If you are enrolled in an MAPD plan and move outside your plan’s ZIP code service area, you must contact EGID to disenroll. To change your coverage to a plan including Part D prescription drug benefits, you must complete an Application for Medicare Supplement With Prescription Drug Plan or an Application for Medicare Advantage Prescription Drug (MAPD) Plan.

Address Information

It is important to keep your mailing and email addresses current, or you risk delaying claims processing or missing important communications. Medicare requires that you report any change in your home address to your insurance plan.

Contact EGID Member Services for a Change of Address form, or submit a written request to:

EGID
3545 N.W. 58th St., Ste. 600
Oklahoma City, OK 73112

You can fax requests for changes to 405-717-8939. Verbal requests for address changes are not accepted.

Confirmation Statement

When you enroll as a former employee or make changes to your coverage, EGID mails you a confirmation statement which lists the coverage you are enrolled in, the effective date of your coverage and the premium amounts.

Check it carefully. If incorrect, immediately contact EGID Member Services. Corrections must be submitted to EGID within 60 days of the election. Corrections reported after 60 days are effective the first of the month following notification.

Option Period

After you leave active employment, EGID mails your Option Period materials directly to you.

To make plan changes, complete your Option Period form and return it directly to EGID. Keep a copy of your form for your records. EGID will mail you a confirmation statement.

If you have no plan changes, do not return your form. You will not receive a confirmation statement.
## Monthly Premiums for Pre-Medicare Former Employees

**Plan Year Jan. 1-Dec. 31, 2020**

### HEALTH PLANS

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Member</th>
<th>Spouse</th>
<th>Child</th>
<th>Children</th>
</tr>
</thead>
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<tr>
<td>Blue Cross Blue Shield of Oklahoma – BlueLincs HMO</td>
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### DENTAL PLANS

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<tr>
<td>Cigna Dental Care Plan (Prepaid)</td>
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<td>Delta Dental PPO – Choice</td>
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### VISION PLANS

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Member</th>
<th>Spouse</th>
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<td>Primary Vision Care Services (PVCS)</td>
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<td>VSP (Vision Service Plan)</td>
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### LIFE PLAN

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<th>Life Plan Description</th>
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<td>From $5,000 to $40,000</td>
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### AGE RATED SUPPLEMENTAL LIFE – Cost Per $1,000 for $41,000 and Up

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<thead>
<tr>
<th>Age Range</th>
<th>Cost Per $1,000</th>
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<tbody>
<tr>
<td>&lt; 30</td>
<td>$0.06</td>
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<tr>
<td>30 - 34</td>
<td>$0.06</td>
</tr>
<tr>
<td>35 - 39</td>
<td>$0.06</td>
</tr>
<tr>
<td>40 - 44</td>
<td>$0.08</td>
</tr>
<tr>
<td>45 - 49</td>
<td>$0.14</td>
</tr>
<tr>
<td>50 - 54</td>
<td>$0.26</td>
</tr>
<tr>
<td>55 - 59</td>
<td>$0.40</td>
</tr>
<tr>
<td>60 - 64</td>
<td>$0.46</td>
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<tr>
<td>65 - 69</td>
<td>$0.74</td>
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<tr>
<td>70 - 74</td>
<td>$1.28</td>
</tr>
<tr>
<td>75+</td>
<td>$1.96</td>
</tr>
</tbody>
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### DEPENDENT LIFE

$1.08 Per $500 Unit, Per Dependent

*These rates do not reflect any retirement system contribution.*
### Monthly Premiums for Medicare Eligible Members
**Plan Year Jan. 1-Dec. 31, 2020**

#### MEDICARE SUPPLEMENT PLANS

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Plan Name</th>
<th>Premium per Covered Person</th>
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<tbody>
<tr>
<td>BCBSOK – BlueSecure™</td>
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<tr>
<td>HealthChoice SilverScript High Option Medicare Supplement</td>
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#### MEDICARE ADVANTAGE PRESCRIPTION DRUG (MAPD) PLANS

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<tbody>
<tr>
<td>MAPD HMO</td>
<td>CommunityCare Senior Health Plan</td>
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<td>Generations by GlobalHealth</td>
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<td>Humana National MAPD</td>
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FORMS
Employees Group Insurance Division
APPLICATION FOR RETIREE/VESTED
NON-VESTED/DEFER INSURANCE COVERAGE

RETIREMENT SYSTEM □ OPERS □ TRS □ OLERS □ OTHER

My member status will be: □ Retiree □ Vested □ Non-vested □ Defer (See instructions on page 3.)

For defer only: Spouse’s Social Security number or member ID number ________________________________

☐ Cancel My Deferment and reinstate my retiree/vested/non-vested insurance coverage.

MEMBER INFORMATION

SSN or Member ID # __________________Member’s Birth Date ___________ Gender □ Male □ Female

Member’s Name __________________________________________ Employer ____________________________

First                  M.I.       Last

Mailing Address __________________________________________

Street __________________ City __________________ State ______ ZIP Code __________

Phone __________________ Alt. Phone __________________ Email Address __________________

MEMBER HEALTH PLAN □ Add/keep □ Drop □ Defer

Health plan name ________________________________ □ Check if Medicare-eligible*

Primary physician (HMO only) ____________________ □ Current patient □ New patient

*If you and/or your dependents are eligible for Medicare, health plan changes are allowed. If you are enrolling in a Medicare health plan, an additional application must be completed.

MEMBER DENTAL PLAN □ Add/keep □ Drop □ Defer

Dental plan name ________________________________

Primary dentist (Prepaid only) ____________________

☐ Current patient □ New patient

MEMBER VISION PLAN □ Add/keep □ Drop □ Defer

Vision plan name: ______________________________

MEMBER LIFE INSURANCE

You can keep a minimum of $5,000 up to the total amount of your current life insurance. You cannot enroll in more life insurance than you currently have. You must keep life insurance on yourself to be able to keep life insurance on your dependents. It is important to consider future life insurance needs because increases cannot be made after this election. Life insurance cannot be deferred and must be carried as a primary retiree/vested member.

☐ I elect to keep $ ________ (5,000 to $40,000 in $5,000 units) of member life insurance at a flat rate per $1,000 of coverage.

☐ I elect to keep $ ________ (amount above $40,000 in $5,000 units) of additional life insurance.
NOTE: If you and/or your dependents are eligible for Medicare, an additional application must be completed. Please contact EGID Member Services to request an application. You cannot add dependent life if you do not already have it. The dependent life amount must be the same for each child, though the amount for your spouse can be different.

### SPouse

<table>
<thead>
<tr>
<th>Add/Keep</th>
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<td>Health</td>
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<td></td>
<td>SSN ______________________ Date of Birth __________________</td>
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<td></td>
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<td></td>
<td></td>
<td>Primary Physician (HMO only) _______</td>
<td>Current Patient □ New Patient</td>
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<tr>
<td></td>
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<td>Vision</td>
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<td>Primary Dentist (Prepaid only) ______</td>
<td>Current Patient □ New Patient</td>
</tr>
<tr>
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<td></td>
<td>Dep Life</td>
<td>I elect to keep $__________________ (in $500 units) of dependent life insurance.</td>
</tr>
</tbody>
</table>

Does your spouse currently have coverage through OMES EGID? □ Yes □ No
(If yes, list name and Social Security number above.)

### CHILD

<table>
<thead>
<tr>
<th>Add/Keep</th>
<th>Drop</th>
<th>Name _______________________________</th>
<th>Check if Medicare-eligible.</th>
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<tbody>
<tr>
<td></td>
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<td>Health</td>
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<td>SSN ______________________ Date of Birth __________________</td>
<td>Male □ Female □</td>
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<td>Dental</td>
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<td>Primary Physician (HMO only) _______</td>
<td>Current Patient □ New Patient</td>
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<td>Vision</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Primary Dentist (Prepaid only) ______</td>
<td>Current Patient □ New Patient</td>
</tr>
<tr>
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<td></td>
<td>Dep Life</td>
<td>I elect to keep $__________________ (in $500 units) of dependent life insurance.</td>
</tr>
</tbody>
</table>

### CERTIFICATION SIGNATURES

- □ I authorize EGID to deduct the amount of my premiums from my retirement check according to Administrative Rule 260:50-3-5. (You must verify with your retirement system that your retirement check will cover your premiums.)
- □ I request EGID direct bill me for my monthly premiums at the mailing address on this form.

Spouse must sign if being excluded from health, dental and/or vision or if they are a common-law spouse.

- □ Spouse exclusion certification: 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 I cannot be added to coverage at a later date except within 30 days of the loss of other coverage. (Required only if children are covered and spouse is not.)
- □ 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; that our relationship is exclusive, as proven by our cohabitation as spouses; and that we do hereby hold ourselves out publicly as married. I am aware this relationship can be dissolved only by legal divorce.

Spouse signature __________________________ Date __________

I understand that no coverage, except vision, can be added at a later date.

Member Signature __________________________ Date __________
Retirement information can be found at www.omes.ok.gov.

You can carry health, dental, vision and life insurance on yourself and your dependents.

The health, dental and life coverage you take into retiree/vested/non-vested status is the only coverage you can have with EGID through your retirement years. If you do not keep coverage now, you cannot add it later. Plan changes can be made during the annual Option Period.

If you are insuring one dependent, you must insure all eligible dependents (for any given coverage) unless they are covered by other insurance or Indian or military benefits. Children who have Indian or military benefits or other insurance may be required to show proof of coverage.

Following your retirement, dependents can be added only within 30 days of one of the following events: birth, adoption or guardianship, marriage or loss of other group insurance.

**DEFER INSTRUCTIONS:** If your spouse has separate coverage through EGID at the time you terminate employment, you can transfer your individual health, dental and/or vision coverage to dependent coverage under your spouse’s coverage. Your spouse must contact their employer to add you as a dependent. You must elect to transfer coverage within 30 days of your termination of employment. Any 30-day break in coverage voids your eligibility to keep coverage in the future. Life insurance cannot be deferred and must be carried as a primary retiree/vested/non-vested member. When you are ready to return to retiree/vested/non-vested status, you must again complete this form and mark the box on Page 1 of your form to cancel your deferment.

**THINGS TO CONSIDER AS A RETIREE WHEN YOU BECOME MEDICARE-ELIGIBLE**

**IMPORTANT:** If you are under age 65 and eligible for Medicare, you must notify EGID and provide your Medicare number as it appears on your Medicare card. Medicare supplement coverage is effective the date you become eligible for Medicare, or the first day of the month following notification of your Medicare eligibility, whichever is later.

When you turn age 65, you have the option to enroll in either a Medicare supplement with prescription drug plan or a Medicare Advantage prescription drug plan.

**All MAPD plans offered through EGID require you to have both Medicare Part A and Medicare Part B.**

If you are eligible and do not enroll in Medicare Part B, there are three Medicare supplement plans available to you: HealthChoice SilverScript High Option Medicare Supplement Plan, HealthChoice SilverScript Low Option Medicare Supplement Plan or BCBSOK – BlueSecure. All medical benefits under these plans are paid as if you are enrolled in both Medicare Part A and Part B. If you are not enrolled in Medicare Part B, your plan will estimate Medicare’s benefits and provide supplemental coverage as if Medicare is the primary carrier. This means HealthChoice or Blue Cross and Blue Shield of Oklahoma pays secondary and you are responsible for the primary share of the claim.

For information concerning HMO, MAPD, Medicare supplement, dental or vision plans, contact their customer service numbers.

For information regarding enrollment, or to obtain an application for a Medicare supplement plan or MAPD plan, 405-717-8780 or toll-free 800-752-9475 or TTY 711 call or contact:

OMES Employees Group Insurance Division
P.O. Box 58010
Oklahoma City, OK 73157-8010

Revised 10/24/2019
Employees Group Insurance Division
APPLICATION FOR MEDICARE SUPPLEMENT
WITH PRESCRIPTION DRUG PLAN

Member ID ___________________________ Phone ___________________________

Email address ___________________________ Alternate phone ___________________________

Member name ___________________________
First _______ M.I. _______ Last _______

Member SSN ___________________________
Date of birth ___________________ Sex ☐ M ☐ F

Dependent name ___________________________
(if enrolling in Medicare) First _______ M.I. _______ Last _______

Dependent SSN ___________________________
Date of birth ___________________ Sex ☐ M ☐ F

Permanent residence ___________________________
(P.O. Box is not allowed) Street ____________ City ____________ State ____________ ZIP Code ____________

Mailing address ___________________________
(if different than above) Street ____________ City ____________ State ____________ ZIP Code ____________

If your dependent is the person enrolling in Medicare, complete the rest of the application using your dependent’s information.

Provide your Medicare insurance information.
We must have this information to process your application.

Take out your red, white and blue Medicare card to complete this section.

Fill out this information as it appears on your Medicare card.

-OR-

Attach a copy of your Medicare card or your letter from Social Security or Railroad Retirement Board.

MEDICARE HEALTH INSURANCE

Name ___________________________

Medicare Number ___________________________

Entitled to ___________________________
Coverage Starts ___________________________

HOSPITAL (PART A) ___________________________
MEDICAL (PART B) ___________________________

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

All medical benefits under HealthChoice and Blue Cross Blue Shield of Oklahoma are paid as if you are enrolled in both Medicare Parts A and B. If you are not enrolled in Medicare Part B, your plan will estimate Medicare’s benefits and provide additional coverage as if Medicare is your primary carrier. This means HealthChoice or Blue Cross Blue Shield will pay secondary, and you are responsible for the primary share of the claim.
Answer the Following Questions

1. In which Medicare supplement with Medicare Part D prescription drug plan do you want to enroll?
   - HealthChoice SilverScript Medicare Supplement Plan
   - BCBSOK – BlueSecure

2. Are you a permanent resident of the United States?  □ Yes  □ No

3. Some individuals may have other drug coverage through private insurance, TRICARE, federal employee health benefits, VA benefits or state pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to your coverage through the Employees Group Insurance Division?  □ Yes  □ No

   If yes, please list the name of your other coverage and your identification number and group number for your coverage:
   Name of other coverage ___________________________ ID# ___________________________ Group#_________________________

4. Are you a resident in a long-term care facility, such as a nursing home?  □ Yes  □ No

   If yes, please provide the name, address, and phone number of the facility.
   Name ___________________________ Address and phone ____________________________

5. Typically, you can enroll in a Medicare prescription drug plan only during the annual enrollment period from Oct. 15 through Dec. 7 of each year. There are a few exceptions that may allow you to enroll in a Medicare prescription drug plan outside of the Annual Enrollment Period.  □ I am enrolling during an Annual Enrollment Period (Option Period).

   Read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an enrollment period. If we later determine that this information is incorrect, you may be disenrolled.

   □ I am new to Medicare.
   □ I recently moved outside of the service area of my current plan. I moved on (insert date) __________
   □ I recently was released from incarceration. I was released on (insert date) ______________________
   □ I recently returned to the U.S. after living permanently outside of the U.S. I returned to the U.S. on (insert date) ______________________
   □ I recently obtained lawful presence status in the U.S. I got this status on (insert date) __________
   □ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) ______________________
   □ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in level of Extra Help, or lost Extra Help) on (insert date) ______________________
   □ I have both Medicare and Medicaid or I get Extra Help paying for my Medicare prescription drug coverage, but I haven’t had a change.
   □ I live in or recently moved out of a long-term care facility (for example, a nursing home or other long-term care facility). I moved/will move into/out of the facility on (insert date) ______________________
   □ I recently left a PACE program on (insert date) ______________________
I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare’s). I lost my drug coverage on (insert date) ________________________________

I am leaving employer or union coverage on (insert date) _______________ ______________________

I belong to a pharmacy assistance program provided by my state.

I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) ________________________________ ____________________________

I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

None of these statements apply to me. Call EGID at 405-717-8780 or toll free 800-752-9475 Monday - Friday, 7:30 a.m. to 4:30 p.m. Central Time to see if you are eligible to enroll. TTY users call 711.

Please read this important information

If you or your dependent(s) are currently a member of a Medicare Advantage Prescription Drug (MAPD) plan, you may already have prescription drug coverage through your MAPD plan that meets your needs. By enrolling in a Medicare supplement with prescription drug plan offered by EGID, your membership in your MAPD plan may end. This will affect your doctor and hospital coverage, as well as your prescription drug benefits. Read the information your MAPD plan sends you, and if you have questions, contact your MAPD plan.

If you or your dependent(s) currently have health coverage from an employer or union, enrolling in a Medicare supplement plan with prescription drug plan offered through EGID could affect your employer or union health benefits. You could lose your employer or union health coverage if you enroll in a Medicare supplement with prescription drug plan offered through EGID. Read the communications your employer or union sends you. If you have questions, visit their website or contact the office listed in their communications. If there is not contact information available, contact your benefits administrator or the office that answers questions about your coverage.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify will not have a coverage gap or a late enrollment penalty. Many people are eligible for these savings and do not even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security toll free at 800-772-1213. TTY users should call toll free 800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp. If you qualify for Extra Help, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

Read and sign next page

By completing this enrollment application, I agree to the following:
The Medicare supplement with prescription drug plans offered through EGID are Medicare supplement and prescription drug plans and have a contract with the federal government. HealthChoice contracts with SilverScript to provide Medicare Part D prescription drug coverage. I understand this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A and Part B coverage. It is my responsibility to inform EGID of any prescription drug coverage I
have or may get in the future. I can be enrolled in only one Medicare Part D prescription drug plan at a time. If I am currently in a Medicare prescription drug plan, my enrollment in a Medicare supplement with prescription drug plan offered by EGID will end that enrollment. Enrollment in one of these plans is generally for the entire year. Once I enroll, I can only leave the plan or make changes if an enrollment period is available, generally during the Annual Enrollment period, unless I qualify for enrollment under certain special circumstances.

I understand I must use my plan’s network pharmacies except in certain emergency situations when I cannot reasonably use a network pharmacy. Once I am a member of one of the Medicare supplement with prescription drug plans offered through EGID, I have the right to appeal plan decisions about payment or services if I disagree. When I receive my Evidence of Coverage document provided by my plan, I will read it to learn the rules I must follow to get coverage.

These Medicare supplement with prescription drug plans serve the entire United States. If I move outside of the U.S., I must notify EGID so I can disenroll and find a plan in my new area. I understand that if I leave the plan and don’t have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare’s), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage if I re-enroll in the future.

**Release of Information:**

By joining this Medicare supplement with prescription drug plan, I acknowledge that the Medicare supplement with prescription drug plans offered by EGID will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that they will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from my plan.

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from my plan.

I understand my signature (or the signature of the person authorized to act on my behalf under the law of the state where I live) on this application means I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request by EGID or Medicare.

**Member Signature** ___________________________ **Date** ______________
(You must return the first four pages of this form to EGID at the address listed below.)

**Dependent Signature** ___________________________ **Date** ______________
(Required only if a dependent is enrolling in Medicare.)

For more information about the plans offered by EGID, contact:

**Employees Group Insurance Division**
P.O. Box 58010, Oklahoma City, OK 73157-8010
405-717-8780 or toll free 800-752-9475 or TTY 711
Website: [http://omes.ok.gov/services/employees-group-insurance-division](http://omes.ok.gov/services/employees-group-insurance-division)

<table>
<thead>
<tr>
<th>MEDICARE SUPPLEMENT WITH PRESCRIPTION DRUG PLANS</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>BCBSOK - BlueSecure</td>
<td>$ 364.02 per covered person</td>
</tr>
<tr>
<td>HealthChoice SilverScript High Option Medicare Supplement</td>
<td>$ 395.30 per covered person</td>
</tr>
<tr>
<td>HealthChoice SilverScript Low Option Medicare Supplement</td>
<td>$ 320.44 per covered person</td>
</tr>
</tbody>
</table>

These rates do not reflect any contribution from your retirement system.
A separate application must be submitted for each Medicare beneficiary enrolling.

Member ID ___________________________ Phone _________________________________

Email address __________________________ Alternate phone _______________________

Member name __________________________ First ___________________________ M.I. ___________ Last _________________

Member SSN ___________________________ Date of birth ___________________ Sex ☐ M ☐ F

Dependent name __________________________ First ___________________________ M.I. ___________ Last _________________
(if enrolling in Medicare)

Dependent SSN __________________________ Date of birth ___________________ Sex ☐ M ☐ F

Permanent residence __________________________ Street __________________ City __________________ State ______ ZIP Code ______ County ______
(P.O. Box is not allowed)

Mailing address __________________________ Street __________________ City __________________ State ______ ZIP Code ______ County ______
(if different than above)

If your dependent is the person enrolling in Medicare, complete the rest of the application using your dependent’s information.

Provide your Medicare insurance information. 
We must have this information to process your application.

Take out your red, white and blue Medicare card to complete this section.

Fill out this information as it appears on your Medicare card.

-OR-

Attach a copy of your Medicare card or your letter from Social Security or Railroad Retirement Board.

MEDICARE HEALTH INSURANCE

Name

_____________________________ _______________________________
Medicare Number

Entitled to Coverage Starts
HOSPITAL (PART A) ________________
MEDICAL (PART B) ________________

You must have Medicare Part A and Part B to join an MAPD plan.

C1 Revised 09/23/2019
Answer the following questions

1. In which MAPD plan do you want to enroll?

   - BCBSOK – MAPD
   - CommunityCare Senior Health Plan
   - Generations by GlobalHealth
   - Humana National MAPD

2. Do you have End Stage Renal Disease (ESRD)?  Yes  No

   *If you have had a successful kidney transplant and/or you don’t need regular dialysis any more, attach a note or records from your doctor showing you have had a successful kidney transplant or you don’t need dialysis, otherwise, the MAPD plan may need to contact you to obtain additional information.*

3. Some individuals may have other prescription drug coverage through private insurance, TRICARE, federal employee health benefits, VA benefits, workers’ compensation, or state pharmaceutical assistance programs. Do you have other prescription drug coverage?  Yes  No

   If yes, please list your other coverage and your identification number(s) for your coverage:
   Name of other coverage ______________________ ID # __________________ Group #________________

4. Typically, you can enroll in an MAPD plan only during the Annual Enrollment Period from Oct. 15 through Dec. 7 of each year. Please check the box below if you are enrolling during the Annual Enrollment Period.

   - I am enrolling during an Annual Enrollment Period (Option Period).

   There are exceptions that may allow you to enroll in an MAPD plan outside of this period.

   Read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an enrollment period. If we later determine this information is incorrect, you may be disenrolled.

   - I am new to Medicare.
   - I recently moved outside the service area of my current plan, or I recently moved and this plan is a new option for me. I moved on (insert date) ____________________________.
   - I recently was released from incarceration. I was released on (insert date) ________________.
   - I recently returned to the U.S. after living permanently outside of the U.S. I returned to the U.S. on (insert date) ____________________________.
   - I recently obtained lawful presence status in the U.S. I got this status on (insert date) ________________.
   - I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in level of Extra Help, or lost Extra Help) on (insert date) ________________.
   - I have both Medicare and Medicaid or I get Extra Help paying for my Medicare prescription drug coverage, but I haven’t had a change.
   - I live in or recently moved out of a long-term care facility (for example, a nursing home). I moved/will move into/out of the facility on (insert date) ____________________________.
   - I recently left a PACE program on (insert date) ____________________________.
I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare’s).

I lost my drug coverage on ____________________________ .

I am leaving employer or union coverage on ____________________________ .

I belong to a pharmacy assistance program provided by my state.

I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on ____________________________ .

I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

None of these statements apply to me. Call the Employees Group Insurance Division at 405-717-8780 or toll free 800-752-9475 Monday - Friday, 7:30 a.m. to 4:30 p.m., Central Time to see if you’re eligible to enroll. TTY users call 771.

5. Would you prefer that the MAPD plan send you information in a language other than English or in another format?

Yes ☐ No ☐ If yes, contact the MAPD plan directly. See contact information on the last page of this application.

PRIMARY CARE PHYSICIAN SELECTION

As an MAPD plan member with CommunityCare Senior Health Plan or Generations by GlobalHealth, you must choose a primary care physician who will coordinate your health care. Once you choose an MAPD plan, you can obtain a list of the plan’s network physicians by contacting the plan or going to the plan’s website. Contact information for the plans may be found on the last page of this application.

Physician’s first name ____________________________

Physician’s last name ____________________________

Are you currently a patient of the physician? ☐ Yes ☐ No

Please read this important information

By completing this enrollment application, I agree to the following:
The MAPD plans offered through EGID are Medicare Advantage Prescription Drug plans and they have a contract with the federal government. I will need to keep my Medicare Parts A and B. I can be in only one MAPD plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform EGID of any prescription drug coverage I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (example: Annual Enrollment Period from Oct. 15-Dec. 7), or under certain special circumstances.

The MAPD plans offered through EGID serve a specific service area. If I move out of that service area, I need to notify EGID and the plan so I can disenroll and find a new plan in my new area. Once I am a member of an MAPD plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the member handbook or Evidence of Coverage document from the MAPD plan when I get it so I know which
rules I must follow to get coverage through my MAPD plan. I understand that people with Medicare aren’t usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date my MAPD plan coverage begins, I must get all of my health care from that plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by the MAPD plan and other services contained in my MAPD Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MY MAPD PLAN WILL PAY FOR SERVICES.**

**Release of Information:** By joining this MAPD health plan, I acknowledge the plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge my MAPD plan will release my information, including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies 1) this person is authorized under state law to complete this enrollment, and 2) documentation of this authority is available upon request from Medicare.

Member signature ___________________________________________ Date ___________________________
(You must return all pages of this form to EGID at the address listed below.)

Dependent signature ___________________________________________ Date ___________________________
(Required only if dependent is enrolling in an MAPD plan.)

If you are the authorized representative, you must sign above and provide the following information:

Name ___________________________________________ Phone ___________________________
Address _______________________________________________________________________________
Relationship to enrollee ___________________________________________________________________

You must return this form to EGID at the address or fax number listed below.
For more information regarding this application, contact EGID.

Employees Group Insurance Division
P.O. Box 58010, Oklahoma City, OK 73157-8010
405-717-8780 or toll free 800-752-9475 or TTY 711
Fax 405-717-8939
**Office of Management and Enterprise Services**  
**Employees Group Insurance Division**  
**Beneficiary Designation Form**

Please read the instructions carefully and complete this form in ink.

**Employer Name**

SSN or Member ID: ___________________  Member Name: ___________________  

Address: 

<table>
<thead>
<tr>
<th>New Address</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>ZIP</th>
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Phone: (____) __________________________  Alt Phone: (____) __________________________

**Important**: Please ensure the “Share Percentage” section in both Primary Beneficiary(ies) and Contingent Beneficiary(ies) add up to 100 percent. Payment will be made in equal shares to all surviving beneficiaries unless otherwise indicated.

### PRIMARY BENEFICIARY(IES)

<table>
<thead>
<tr>
<th>Primary Beneficiary's Name and Address</th>
<th>SSN</th>
<th>Phone #</th>
<th>Relationship</th>
<th>Date of Birth</th>
<th>Share Percentage</th>
</tr>
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100%

### CONTINGENT BENEFICIARY(IES)

Proceeds are paid to the contingent beneficiary(ies) identified below only if there is no surviving primary beneficiary(ies).

<table>
<thead>
<tr>
<th>Contingent Beneficiary's Name and Address</th>
<th>SSN</th>
<th>Phone #</th>
<th>Relationship</th>
<th>Date of Birth</th>
<th>Share Percentage</th>
</tr>
</thead>
<tbody>
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100%

I have named the above beneficiary(ies) to receive my life insurance benefits from HealthChoice. I understand this form replaces and cancels all prior beneficiary designations and will become effective only when it is received by EGID.

_________________________ __________________________
Member Signature - original signature required  Date

Mail this form to OMES EGID at 3545 N.W. 58th St., Ste. 600, Oklahoma City, OK 73112
Instructions for Completing the Beneficiary Designation Form

This beneficiary form applies to the HealthChoice Life Insurance Plan offered through the Office of Management and Enterprise Services Employees Group Insurance Division. If you are retired, it does not affect the beneficiaries for any death benefit you may have through your retirement system.

The beneficiary designations you make on this form replace and cancel all prior life insurance beneficiary designations with EGID. Your designations do not become effective until this form is signed and received by EGID. Do not alter this form or attach additional pages.

It is very important that you provide the full legal name, address, relationship, date of birth and Social Security number of each beneficiary you designate. This information is essential in ensuring that your named beneficiaries can be located and receive your intended benefit amount. The Beneficiary Designation Form has three parts: Member Information, Primary and Contingent Beneficiary Designation and Signature. Please print clearly in ink.

**Employer Name** – Provide the name of your employer. This information is not required of a former employee/retiree.

**Member Information** – Provide your name, SSN or Member ID and address.

**Primary Beneficiary Designation** – You can designate one or more primary beneficiaries. All primary beneficiaries share equally, unless you note otherwise. In the event that multiple primary beneficiaries are named and a primary beneficiary dies before or simultaneously with you, the remaining primary beneficiary(ies) will be entitled to equal share of the deceased beneficiary’s designated benefit amount.

**Contingent Beneficiary Designation** – You can designate one or more contingent beneficiaries. Contingent beneficiaries receive benefits only in the event all primary beneficiaries die before or simultaneously with you. All contingent beneficiaries share equally, unless you note otherwise on your form. In the event that multiple contingent beneficiaries are named and a contingent beneficiary dies before or simultaneously with you, the remaining contingent beneficiary(ies) will be entitled to equal share of the deceased beneficiary’s designated benefit amount.

**Signature** – You must sign and date your form.

**Special Beneficiary Designations**
Sometimes members wish to make a special designation for trusts, minors or institutions. If you wish to make a special designation, please read the following information carefully.

**Designating a trust as beneficiary** – To designate a trust as beneficiary, provide the actual name of the trust and the date the trust was created in the space provided.

**Designating a minor as beneficiary** – A minor can be named your beneficiary; however, it is often difficult and costly for a minor to receive payment, especially if the amount exceeds $10,000. Before you designate a minor as your beneficiary, you should consult an attorney or professional financial advisor.

**Designating an institution as beneficiary** – To designate an institution (church, charity, funeral home, etc.) as your beneficiary, provide the full name of the institution and list the address in the space provided.

**After you complete and sign the Beneficiary Designation Form, mail it to:**

Office of Management and Enterprise Services
Employees Group Insurance Division
3545 N.W. 58th St., Ste. 600
Oklahoma City, OK 73112

Remember to keep a copy of your completed form for your records.
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

For questions or complaints regarding privacy concerns with OMES, please contact:

OMES HIPAA Privacy Officer
3545 N.W. 58th, Ste. 600, Oklahoma City, OK 73112
Telephone 405-717-8780, Toll-free 800-543-6044
TTY 711
OMES.OK.gov

Why is the Notice of Privacy Practices Important?
This notice provides important information about the practices of OMES pertaining to the way OMES gathers, uses, discloses, and manages your protected health information (PHI) and it also describes how you can access this information. PHI is health information that can be linked to a particular person by certain identifiers including, but not limited to, names, social security numbers, addresses and birth dates.

Oklahoma privacy laws and the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) protect the privacy of an individual's health information. For HIPAA purposes, OMES has designated itself as a hybrid entity. This means that HIPAA only applies to areas of OMES operations involving health care, and not to all lines of service offered by OMES. This notice applies to the privacy practices of the following components included within OMES that may share or access your Protected Health Information as needed for treatment, payment and health care operations:

- The Employees Group Insurance Division (EGID).
- The Legal division.
- The Information Services division as it applies to maintenance and storage of PHI.

OMES is committed to protecting the privacy and security of your PHI as used within the components listed above.

Your Information. Your Rights. Our Responsibilities.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.
Get a copy of your health and claims records
- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this using the contact information at the beginning of this notice.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable fee.

Ask us to correct health and claims records
- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we will tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information
- You can ask for an accounting of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year free of charge but will charge a reasonable fee if you ask for another accounting within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will verify the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information at the beginning of this notice.
- You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington,
D.C. 20201, calling 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. Complaints to HHS must be filed within 180 days of when you knew that the violation occurred.

- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care.
- Share information in a disaster relief situation.

If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent health or safety threat.

OMES does not share your information for purposes of marketing or by sale of your information.

Our Uses and Disclosures

How do we typically use or share your health information (PHI)?

Your PHI is used and disclosed by OMES employees and other entities under contract with OMES according to HIPAA Privacy Rules using the “minimum necessary” standard which releases only the minimum necessary health information to achieve the intended purpose or to carry out a desired function within OMES.

We typically use or share your health information in the following ways:

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Examples: We use health information about you to develop better services for you, provide
customer service, resolve member grievances, member advocacy, conduct activities to improve members’ health and reduce costs, assist in the coordination and continuity of health care, and to set premium rates.

Pay for your health services
We can use and disclose your health information as we pay for your eligible health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose summarized health information to your health plan sponsor for plan administration.

Example: Your employer contracts with us to provide a health plan, and we provide the employer with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, refer to www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease.
- Helping with product recalls.
- Reporting adverse reactions to medications.
- Reporting births and deaths.
- Reporting suspected abuse, neglect, or domestic violence.
- Preventing or reducing a serious threat to anyone’s health or safety.
- Public health investigations.

Do research
We can use or share your information for health research, as permitted by law.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy laws.

Work with a medical examiner or funeral director
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers’ compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers’ compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information (PHI).
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your PHI.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your PHI other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, refer to [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will deliver a copy to you. You may also subscribe online at [https://public.govdelivery.com/accounts/OKOMES/subscriber/new](https://public.govdelivery.com/accounts/OKOMES/subscriber/new) to receive notice of changes to this page via email or text message.
Contact Information

**Health Plans**

Blue Cross Blue Shield of Oklahoma  
855-609-5684  
TTY 711  
www.bcbsok.com/state

CommunityCare  
918-594-5242 or 800-777-4890  
TDD 800-722-0353  
state.ccok.com

CommunityCare Senior Health Plan  
800-642-8065  
TDD 800-722-0353  
www.ccok.com

Generations by GlobalHealth  
Current members:  
405-280-5555 or 844-280-5555  
Prospective members:  
844-322-8422 or TTY 711  
www.globalhealth.com/medicare

GlobalHealth, Inc.  
405-280-5600 or 877-280-5600  
TDD 711  
www.globalhealth.com

HealthChoice  
Customer Care 800-323-4314  
TTY 711  
www.healthchoiceconnect.com

Humana  
866-396-8810  
TTY 711  
www.humana.com

**Dental Plans**

Cigna Prepaid Dental  
800-244-6224  
Hearing-impaired relay 800-654-5988  
www.cigna.com

Delta Dental  
405-607-2100 or 800-522-0188  
DeltaDentalOK.org/client/OK

HealthChoice  
Customer Care 800-323-4314  
TTY 711  
www.healthchoiceconnect.com

MetLife  
855-676-9443  
www.metlife.com/oklahoma

Sun Life  
800-442-7742  
www.sunlife.com

**Life Plan**

HealthChoice  
Customer Care 800-323-4314  
TTY 711  
www.healthchoiceconnect.com
Contact Information

**Vision Plans**

Primary Vision Care Services (PVCS)
888-357-6912
TDD 800-722-0353
[www.pvcs-usa.com](http://www.pvcs-usa.com)

Superior Vision
800-507-3800
TDD 916-852-2382
[www.superiorvision.com](http://www.superiorvision.com)

Vision Care Direct
877-488-8900
TTY 711
[www.okstate.vision](http://www.okstate.vision)

VSP
800-877-7195
TDD 800-428-4833
[www.vsp.com](http://www.vsp.com)

**Other Important Numbers**

Employees Group Insurance Division
405-717-8780 or 800-752-9475
TTY 711
[omes.ok.gov](http://omes.ok.gov)

Social Security Administration
800-772-1213
TTY 800-325-0778
[SSA.gov](http://SSA.gov)

Medicare
800-633-4227
TTY 877-486-2048
[Medicare.gov](http://Medicare.gov)

Oklahoma Public Employees Retirement System
405-858-6737 or 800-733-9008
[www.opers.ok.gov](http://www.opers.ok.gov)

Oklahoma Teachers' Retirement System
405-521-2387 or 877-738-6365
[www.ok.gov/trs](http://www.ok.gov/trs)

Oklahoma Law Enforcement Retirement System
405-522-4931 or 877-213-0856
[www.olvers.state.ok.us](http://www.olvers.state.ok.us)
# Forms You Must Complete to Continue Insurance When You Leave Active Employment

<table>
<thead>
<tr>
<th>Insurance Forms</th>
<th>If You Are a Pre-Medicare Member</th>
<th>If You Are a Member Enrolling in a Medicare Supplement Plan</th>
<th>If You Are a Member Enrolling in a Medicare Advantage Prescription Drug (MAPD) Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage (Page A1)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Application for Medicare Supplement With Prescription Drug Plan (Page B1)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Each enrollee must complete an application</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Application for Medicare Advantage Prescription Drug (MAPD) Plan (Page C1)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Each enrollee must complete an application</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beneficiary Designation Form (If continuing life insurance coverage) (Page D1)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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