Employees Group Insurance Division

2021 OPTION PERIOD ENROLLMENT/CHANGE FORM

COBRA MEMBERS

IF MAKING CHANGES, RETURN TO: OMES EGID, P.O. BOX 58010, OKLAHOMA CITY, OK 73157-8010
MUST BE POSTMARKED BY DEC. 7, 2020.

MEMBER INFORMATION (please print)

Member name ______________________________ **Member ID/SSN** ____________________

Mailing address ______________________________ **Phone** ____________________

☐ **New address** ______________________________ **Alt phone** ____________________

City **State** **ZIP code**

Email address ______________________________

ALL CHANGES ARE EFFECTIVE JAN. 1, 2021.
See back of form for dependent changes and signatures.

Health Plan

☐ **No change** ☐ **Add or change health plan** ☐ **Drop health plan**

To ADD or CHANGE your health plan, select from the options below:

- ☐ 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 online Tobacco-Free Attestation or reasonable alternative.**

- ☐ HealthChoice High Deductible Health Plan (HDHP)

Member primary physician (HMO only) ____________________ ☐ New patient ☐ Current patient

Dental Plan

☐ **No Change** ☐ **Add or change dental plan** ☐ **Drop dental plan**

To ADD or CHANGE your dental plan, select from the options below:

- ☐ BCBSOK BlueCare Dental High Plan
- ☐ BCBSOK BlueCare Dental Low Plan
- ☐ Cigna Prepaid High (K1I09)
- ☐ Cigna Prepaid Low (OKIV9)
- ☐ Delta Dental PPO – Choice
- ☐ Delta Dental PPO
- ☐ HealthChoice Dental
- ☐ MetLife High Classic MAC
- ☐ MetLife Low Classic MAC
- ☐ Sun Life Preferred Active PPO

Member primary dentist (prepaid only) ____________________ ☐ New patient ☐ Current patient

Vision Plan

☐ **No change** ☐ **Add or change vision plan** ☐ **Drop vision plan**

To ADD or CHANGE your vision plan, select from the options below:

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

DEPENDENT CHANGES

SPOUSE

	ADD	**DROP**
Health	☐	☐
Dental	☐	☐
Vision	☐	☐

Name ______________________ SSN ______________________
Date of birth ______________________ ☐ Male ☐ Female
Primary physician ______________________ ☐ New patient ☐ Current patient
Primary dentist ______________________ ☐ New patient ☐ Current patient

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

CHILD

	ADD	**DROP**
Health	☐	☐
Dental	☐	☐
Vision	☐	☐

Name ______________________ SSN ______________________
Date of birth ______________________ ☐ Male ☐ Female
Primary physician ______________________ ☐ New patient ☐ Current patient
Primary dentist ______________________ ☐ New patient ☐ Current patient

CHILD

	ADD	**DROP**
Health	☐	☐
Dental	☐	☐
Vision	☐	☐

Name ______________________ SSN ______________________
Date of birth ______________________ ☐ Male ☐ Female
Primary physician ______________________ ☐ New patient ☐ Current patient
Primary dentist ______________________ ☐ New patient ☐ Current patient

CHILD

	ADD	**DROP**
Health	☐	☐
Dental	☐	☐
Vision	☐	☐

Name ______________________ SSN ______________________
Date of birth ______________________ ☐ Male ☐ Female
Primary physician ______________________ ☐ New patient ☐ Current patient
Primary dentist ______________________ ☐ New patient ☐ Current patient

CERTIFICATION SIGNATURES

Member signature ______________________________ **Date** ______________

SPOUSE MUST SIGN IF COMMON-LAW.

☐ **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 signature ______________________________ **Date** ______________

If making changes, complete and return no later than Dec. 7, 2020, to:
OMES EGID, P.O. Box 58010, OKLAHOMA CITY, OK 73157-8010.

<u>If you are not making changes, do not return this form.</u>