Employees Group Insurance Division

2021 OPTION PERIOD ENROLLMENT/CHANGE FORM

COBRA MEDICARE 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 required signatures and changes to dependent coverage.

Health Plan

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

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

Remember, you and your dependents must all have coverage under the same plan. For example, if you are enrolled in a HealthChoice plan and you are currently insuring dependents, your dependents must also be enrolled in a HealthChoice plan. If you are enrolled in an HMO plan, your dependents must be enrolled in the same HMO.

To elect a *MEDICARE* plan for yourself and/or your covered dependents, select from the list below:

☐ BCBSOK – BlueSecure*
☐ High ☐ Low HealthChoice SilverScript Medicare Supplement Plan*
☐ BCBSOK – MAPD*
☐ CommunityCare Senior Health Plan*
☐ Generations by GlobalHealth*
☐ Humana National MAPD*

*If you and/or your Medicare eligible dependents are enrolling in or changing to a different Medicare supplement or MAPD plan, you/they must obtain and complete a separate enrollment application and complete and return this Option Period form to EGID.

To elect a *PRE*-Medicare plan for yourself and/or your covered dependents, select from the list 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

Revised 08/17/2020

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

☐ Pre-Medicare OR ☐ Medicare

	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

☐ Pre-Medicare OR ☐ Medicare

	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 SIGNATURE

You must sign this form. Additionally, if you and/or your Medicare-eligible dependents are enrolling in or changing to a different Medicare supplement or MAPD plan, you/they must obtain and complete a separate enrollment application AND complete and return this Option Period form to EGID.

Member 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>