OKLAHOMA
Office of Management & Enterprise Services

Employees Group Insurance Division

2021 OPTION PERIOD ENROLLMENT/CHANGE FORM

FORMER EMPLOYEES AND SURVIVING DEPENDENTS

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.

CAUTION: If you drop your health and/or dental coverage and either drop or reduce your life insurance coverage, you cannot regain this coverage in the future. If you drop coverage (except vision) on your dependent, you cannot regain this coverage in the future unless your dependent loses other coverage.

Health Plan ☐ **No change** ☐ **Change health plan** ☐ **Drop health plan**

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

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

Dental Plan ☐ No change ☐ Change dental plan ☐ Drop dental plan

To 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

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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)

Life Plan ☐ No change ☐ Drop all life insurance

☐ **Decrease life insurance to $** _____ (in $5,000 units)

DEPENDENT CHANGES

SPOUSE ☐ Pre-Medicare OR ☐ Medicare

Name _____ SSN _____

	ADD	DROP
Health	N/A	☐
Dental	N/A	☐
Vision	☐	☐
Dependent Life	N/A	☐

Date of birth _____ ☐ Male ☐ Female

Primary physician _____ ☐ New patient ☐ Current patient

Primary dentist _____ ☐ New patient ☐ Current patient

☐ Decrease Dependent Life amount to $ _____ (in $500 units)

CHILD ☐ Pre-Medicare OR ☐ Medicare

Name _____ SSN _____

	ADD	DROP
Health	N/A	☐
Dental	N/A	☐
Vision	☐	☐
Dependent Life	N/A	☐

Date of birth _____ ☐ Male ☐ Female

Primary physician _____ ☐ New patient ☐ Current patient

Primary dentist _____ ☐ New patient ☐ Current patient

☐ Decrease Dependent Life amount to $ _____ (in $500 units)

CERTIFICATION SIGNATURES

Member signature _____ **Date** _____

Your spouse must sign if they are being excluded from health, dental and/or vision coverage.

☐ **Spouse Exclusion Certification** (required only if dropping spouse while continuing to cover children):
I certify that I am aware I am being **excluded** from health, dental and/or vision coverage as indicated on this form.

Spouse signature _____ **Date** _____

If you are not making changes, do not return this form.