OKLAHOMA
Employees Group Insurance Division

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INSURANCE CHANGE FORM
CURRENT EMPLOYEES

IMPORTANT! Read the Plan Guidelines (Page 3) before completing this form.

Employer information (to be completed by insurance coordinator)

Group ID	Division ID	Group name

Employee information

Name (First MI Last)		Legal name change ☐ From: To:	
SSN or Member ID	Date of birth	☐ Male ☐ Female	☐ Married ☐ Single

Mailing address City State ZIP code

Phone	Alt phone	Email
Effective date of coverage (MM/01/YYYY)		Alt email

Health plan election

☐ **No change** ☐ **Add** ☐ **Drop**

- ☐ BCBSOK – BlueLincs HMO
- ☐ CommunityCare HMO
- ☐ GlobalHealth HMO
- ☐ HealthChoice High
- ☐ HealthChoice Basic
- ☐ HealthChoice High Deductible Health Plan (HDHP)

Employee primary physician (HMO only) ☐ Current patient ☐ New patient

Dental plan election

☐ **No change** ☐ **Add** ☐ **Drop**

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

Employee primary dentist (Prepaid only) ☐ Current patient ☐ New patient

Vision plan election

☐ **No change** ☐ **Add** ☐ **Drop**

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

Life plan election (proof of loss for qualifying event required to add)

☐ **No change** ☐ **Add** ☐ **Drop**

Basic and Supplemental Life can be added midyear only within 30 days of the loss of other group life insurance. You can request coverage up to the amount lost, rounded to the next $20,000 unit. Your request must include proof of loss of the other group life coverage indicating date of loss and amount of coverage. The maximum amount of Supplemental Life available is $500,000.

☐ Basic Life (required for enrollment in Supplemental Life)	$
☐ Supplemental Life (in $20,000 units)	$
Total Basic and Supplemental Life insurance requested:	$0

FOR EGID USE ONLY

Dependent Life plan election (Member Life required to add)

☐ **No change** ☐ **Add** ☐ **Drop**

- ☐ Premier Option (spouse = $20,000, each child = $10,000)
- ☐ Standard Option (spouse = $10,000, each child = $5,000)
- ☐ Low Option (spouse = $6,000, each child = $3,000)

Dependent elections

Spouse name		Health ☐ Add ☐ Drop Vision ☐ Add ☐ Drop Dental ☐ Add ☐ Drop Dependent Life ☐ Add ☐ Drop
SSN	☐ Male ☐ Female	Primary physician ☐ Current patient ☐ New patient
Date of birth	Date of death	Primary dentist ☐ Current patient ☐ New patient

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

Child name		Health ☐ Add ☐ Drop Vision ☐ Add ☐ Drop Dental ☐ Add ☐ Drop Dependent Life ☐ Add ☐ Drop
SSN	☐ Male ☐ Female	Primary physician ☐ Current patient ☐ New patient
Date of birth	Date of death	Primary dentist ☐ Current patient ☐ New patient

Child name		Health ☐ Add ☐ Drop Vision ☐ Add ☐ Drop Dental ☐ Add ☐ Drop Dependent Life ☐ Add ☐ Drop
SSN	☐ Male ☐ Female	Primary physician ☐ Current patient ☐ New patient
Date of birth	Date of death	Primary dentist ☐ Current patient ☐ New patient

Child name		Health ☐ Add ☐ Drop Vision ☐ Add ☐ Drop Dental ☐ Add ☐ Drop Dependent Life ☐ Add ☐ Drop
SSN	☐ Male ☐ Female	Primary physician ☐ Current patient ☐ New patient
Date of birth	Date of death	Primary dentist ☐ Current patient ☐ New patient

To list additional dependents, please obtain the Dependent Attachment Form from your insurance coordinator.

Signatures

I certify all selections made on this form are true and in compliance with the Plan Guidelines for Insurance Enrollment. I agree to deliver documentation that authenticates this statement to EGID upon request.

Employee signature	Date

Spouse must sign if common-law or excluded from health, dental and/or vision coverage.

☐ **Common-law spouse certification:** I certify that this person listed above as my spouse and I have an actual and mutual agreement between ourselves to be married; 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 (only required if children are covered and spouse is not):** 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 an employee who elects to cover all eligible dependent children and not their spouse will not have the opportunity to enroll their spouse until the next annual Option Period or when a change of status event occurs.

Spouse signature	Date

I certify this enrollment is in compliance with the provisions of the employer's Section 125 Plan or, if no 125 Plan is offered, is in compliance with new hire or allowed midyear coverage enrollments as defined by 26 U.S. Code § 125 of the Internal Revenue Code (as amended) and pertinent regulations. I further certify that on this date, this employee's annual salary listed below (if required) is correct to the best of my knowledge.

Insurance coordinator signature	Date

This form must be returned to your insurance coordinator.

PLAN GUIDELINES FOR INSURANCE CHANGES
Please detach and keep for your records.

Signatures on your form certify that you have read this page and all your elections meet the Plan Guidelines. Refer to 74 O. S. § 1323, Penalties for Knowingly Making False Statements.

Changing coverage for yourself and/or your dependents

Midyear changes – To be eligible to add, drop or change coverage on yourself and/or your dependents after your initial enrollment (other than Option Period), you must experience a midyear qualifying event. You must make your elections and sign this form within 30 days of the qualifying event.

Strict rules apply to all qualifying events. Benefit changes must be consistent with the qualifying event. Changes must also be necessary or appropriate as a result of the qualifying event; e.g., adding health coverage (a benefit election change) is **not** consistent with the loss of a dependent (qualifying event). **Midyear changes eligible within plan guidelines include:**

- Change in your legal marital status.
- Change in your number of dependents.
- Change in your or your dependent's employment status that directly affects eligibility.
- An event that causes your dependent to satisfy, or cease to satisfy, eligibility requirements (age 26, etc.).
- Changes in your or your dependent's place of residence that directly effects eligibility or HMO/DMO availability.
- Beginning or returning from FMLA leave, leave without pay, USERRA leave or disability leave.

Changes that do not fall into the above categories are generally not allowed except during Option Period. If you have questions regarding a midyear qualifying event, please contact your insurance coordinator.

If you declined member or dependent life coverage because you had group life coverage through a source other than your participating employer and later lose that coverage, you can request coverage (up to the amount lost, rounded up to the next $20,000 unit) under the Plan within 30 days of loss of the other group life coverage. Your request must be accompanied by proof of loss of the other group life coverage that indicates the date of loss and the amount of coverage. A life insurance application is not required if coverage is requested within this 30-day period. To be eligible to add Dependent Life and enroll your dependents as a midyear qualifying event, you must first be enrolled in or qualify to add at least Basic Life at that time.

To be eligible to add dental and/or life coverage through EGID, you must first be enrolled in or qualify to add health coverage at that time. You can exclude health coverage if you have other verifiable health coverage. You may be asked to provide proof of that coverage. Failure to provide proof upon request will result in termination of all coverage.

Dependent coverage

Dependent children must be under 26 to be eligible for enrollment.

Your dependents are not eligible for any coverage in which you are not enrolled. If you cover one eligible dependent, you must cover all your eligible dependents. You can elect not to cover dependents who do not reside with you, are married, are not financially dependent on you for support, have other qualified health coverage, or are eligible for Indian or military benefits. You may be asked to provide proof of that coverage. Failure to provide proof when requested will result in termination of coverage for your dependents.

You can cover your children and exclude your spouse from health, dental and/or vision coverage. If you choose this option, your spouse must sign and date the Spouse exclusion certification in the Signatures section on Page 2.

You can cover your children and exclude your spouse from Dependent Life coverage only if your spouse has other qualified life coverage. You may be asked to provide proof of that coverage. Failure to provide proof when requested will result in termination of all coverage.

Once publicly declared, a common-law relationship can be dissolved only by legal divorce.

Notification time limits – The deadline for submitting this form to EGID is strictly enforced. Forms not received within the specified time will not be processed. Your form must be received by EGID within 40 days of the qualifying event.

Confirmation Statement − When you make changes to your coverage, EGID sends you a Confirmation Statement that lists the coverage you are enrolled in, the effective date of your coverage and the premium amounts. It allows you to review your coverage so that any errors can be identified and corrected. Corrections must be submitted to your insurance coordinator or EGID within 60 days of the election. Corrections reported after 60 days are effective the first of the month following notification.