



Employees Group Insurance Division
2027 OPTION PERIOD ENROLLMENT/CHANGE FORM
FORMER EMPLOYEES AND SURVIVING DEPENDENTS

If you are not making changes, do not return this form. All changes are effective Jan. 1, 2027.

Member information

Member name (First MI Last)			Member ID/SSN	
Date of birth	☐ Male ☐ Female	☐ Married ☐ Single		
Mailing address (☐ New)		City	State	ZIP code
Phone	Alt phone		Email	

CAUTION: If you drop your health or dental coverage or drop or reduce your life insurance coverage, you cannot regain this coverage in the future. This also applies to your dependents unless they lose other coverage.

Medicare health plan election – Select a plan to change

- ☐ **No change** ☐ **Change** ☐ **Drop all health coverage**
- ☐ CommunityCare Senior Health Plan ☐ HealthChoice High SilverScript Medicare Supplement Plan
☐ Generations by GlobalHealth ☐ HealthChoice Low SilverScript Medicare Supplement Plan
☐ Humana MAPD PPO

If enrolling in or changing to a different Medicare plan, you and/or your dependents must also complete a Medicare Part D application and return it with this form.

Pre-Medicare health plan election – Select a plan to change

- ☐ **No change** ☐ **Change** ☐ **Drop all health coverage**
- ☐ CommunityCare HMO ☐ HealthChoice High* or High Alternative
☐ GlobalHealth HMO ☐ HealthChoice Basic* or Basic Alternative
☐ HealthChoice High Deductible Health Plan (HDHP) *Must complete online Tobacco-Free Attestation or reasonable alternative by Dec. 7, 2026.

Name of member's primary physician (HMO only):

- ☐ Current patient ☐ New patient

Dental plan election – Select a plan to change

- ☐ **No change** ☐ **Change** ☐ **Drop all dental coverage**
- ☐ BCBSOK BlueCare Dental High Plan ☐ HealthChoice Dental
☐ BCBSOK BlueCare Dental Low Plan ☐ MetLife High Classic MAC
☐ Cigna Prepaid (GAOV9) ☐ MetLife Low Classic MAC
☐ Delta Dental PPO – Choice ☐ Sun Life Preferred Active PPO
☐ Delta Dental PPO

Name of member's primary dentist (Prepaid only):

- ☐ Current patient ☐ New patient

Vision plan election – Select a plan to add or change

- ☐ **No change** ☐ **Add or change** ☐ **Drop all vision coverage**
- ☐ Primary Vision Care Services (PVCS) ☐ Unity Vision (formerly Vision Care Direct)
☐ Superior Vision ☐ VSP (Vision Service Plan)

Member Life plan election (decreasing is in \$500 units)

- ☐ **No change** ☐ **Drop all life coverage**
- ☐ **Decrease Member Life insurance to: \$** _____

Dependent elections (decreasing Dependent Life is in \$5,000 units)

Spouse name ☐ Pre-Medicare ☐ Medicare		Health ☐ Drop Dental ☐ Drop	Vision ☐ Add ☐ Drop Dependent Life ☐ Drop Decrease Dependent Life to: \$
SSN		Primary physician ☐ Current patient ☐ New patient	
Date of birth	☐ Male ☐ Female	Primary dentist ☐ Current patient ☐ New patient	
Child name ☐ Pre-Medicare ☐ Medicare		Health ☐ Drop Dental ☐ Drop	Vision ☐ Add ☐ Drop Dependent Life ☐ Drop Decrease Dependent Life to: \$
SSN		Primary physician ☐ Current patient ☐ New patient	
Date of birth	☐ Male ☐ Female	Primary dentist ☐ Current patient ☐ New patient	
Child name ☐ Pre-Medicare ☐ Medicare		Health ☐ Drop Dental ☐ Drop	Vision ☐ Add ☐ Drop Dependent Life ☐ Drop Decrease Dependent Life to: \$
SSN		Primary physician ☐ Current patient ☐ New patient	
Date of birth	☐ Male ☐ Female	Primary dentist ☐ Current patient ☐ New patient	
Child name ☐ Pre-Medicare ☐ Medicare		Health ☐ Drop Dental ☐ Drop	Vision ☐ Add ☐ Drop Dependent Life ☐ Drop Decrease Dependent Life to: \$
SSN		Primary physician ☐ Current patient ☐ New patient	
Date of birth	☐ Male ☐ Female	Primary dentist ☐ Current patient ☐ New patient	

To list additional dependents, please obtain the Dependent Attachment Form from EGID.

Signatures

Member signature	Date
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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.

Spouse signature	Date
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If making changes, return completed form(s) no later than Dec. 7, 2026, to:

EGID

P.O. Box 11137

Oklahoma City, OK 73136-9998