



**APPLICATION FOR RETIREE/VESTED/  
NON-VESTED/DEFER INSURANCE COVERAGE**

**Retirement information**

Retirement system: ☐ OPERS ☐ TRS ☐ OLERS ☐ PATHFINDER ☐ OTHER

My member status will be: ☐ Retiree ☐ Vested ☐ Non-vested ☐ Defer (see instructions on Page 3)

**Defer only** – Spouse's Social Security number or member ID number:

☐ Cancel my deferment and reinstate my retiree/vested/non-vested insurance coverage.

**Member information**

|                             |                  |
|-----------------------------|------------------|
| Member name (First MI Last) | Member ID or SSN |
|-----------------------------|------------------|

|          |               |                                                               |
|----------|---------------|---------------------------------------------------------------|
| Employer | Date of birth | <input type="checkbox"/> Male <input type="checkbox"/> Female |
|----------|---------------|---------------------------------------------------------------|

|                                                 |      |       |          |
|-------------------------------------------------|------|-------|----------|
| Mailing address ( <input type="checkbox"/> New) | City | State | ZIP code |
|-------------------------------------------------|------|-------|----------|

|       |           |       |
|-------|-----------|-------|
| Phone | Alt phone | Email |
|-------|-----------|-------|

| Last date of employee insurance coverage |     |      | Vested/Non-vested insurance effective date |     |      | Retirement insurance effective date |     |      |
|------------------------------------------|-----|------|--------------------------------------------|-----|------|-------------------------------------|-----|------|
| Month                                    | Day | Year | Month                                      | Day | Year | Month                               | Day | Year |
|                                          |     |      |                                            | 01  |      |                                     | 01  |      |

**Health plan**

☐ Add/keep ☐ Drop ☐ Defer

Health plan name:

☐ Current patient ☐ New patient

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

☐ Medicare eligible. (If you and/or your dependents are Medicare eligible, a Medicare Part D application is required with this form. Please contact EGID Member Services.)

**Dental plan**

☐ Add/keep ☐ Drop ☐ Defer

Dental plan name:

☐ Current patient ☐ New patient

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

**Vision plan**

☐ Add/keep ☐ Drop ☐ Defer

Vision plan name:

**Member Life plan election**

☐ I elect to keep \$ \_\_\_\_\_ (\$5,000 to \$40,000 in \$5,000 units) of member life insurance at a flat rate per \$1,000 of coverage.

☐ I elect to keep \$ \_\_\_\_\_ (amount above \$40,000 in \$5,000 units) of additional life insurance.

You can keep a minimum of \$5,000 up to the total amount of your current life insurance. You cannot add life insurance. You must keep life insurance on yourself to keep dependent life insurance. Life insurance cannot be deferred and must be carried as a primary retiree/vested member.

For EGID use only

## Dependent information

**Notes:** 1) If your dependents are Medicare eligible, a Medicare Part D application is required with this form. Please contact EGID Member Services. 2) You cannot add dependent life if you do not currently have it. The dependent life amount must be the same for each child; the amount for your spouse can be different. You can keep all or decrease dependent life coverage in \$500 units.

|                                                                                                                                             |                                                                                                              |               |                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|---------------|------------------------------------------------------------------|
| <b>Spouse name</b> <input type="checkbox"/> Medicare eligible                                                                               | SSN                                                                                                          | Date of birth | <input type="checkbox"/> Male<br><input type="checkbox"/> Female |
| Do you currently have coverage through EGID? (If yes, list name and SSN above.)<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                              |               |                                                                  |
| Health <input type="checkbox"/> <b>Add/keep</b> <input type="checkbox"/> <b>Drop</b>                                                        | Primary physician (HMO only) <input type="checkbox"/> Current patient <input type="checkbox"/> New patient   |               |                                                                  |
| Dental <input type="checkbox"/> <b>Add/keep</b> <input type="checkbox"/> <b>Drop</b>                                                        | Primary dentist (Prepaid only) <input type="checkbox"/> Current patient <input type="checkbox"/> New patient |               |                                                                  |
| Vision <input type="checkbox"/> <b>Add/keep</b> <input type="checkbox"/> <b>Drop</b>                                                        |                                                                                                              |               |                                                                  |
| Dep. Life <input type="checkbox"/> <b>Add/keep</b> <input type="checkbox"/> <b>Drop</b>                                                     | <input type="checkbox"/> I elect to keep \$ _____ (in \$500 units) of Dependent Life.                        |               |                                                                  |
| <b>Child name</b> <input type="checkbox"/> Medicare eligible                                                                                | SSN                                                                                                          | Date of birth | <input type="checkbox"/> Male<br><input type="checkbox"/> Female |
| Health <input type="checkbox"/> <b>Add/keep</b> <input type="checkbox"/> <b>Drop</b>                                                        | Primary physician (HMO only) <input type="checkbox"/> Current patient <input type="checkbox"/> New patient   |               |                                                                  |
| Dental <input type="checkbox"/> <b>Add/keep</b> <input type="checkbox"/> <b>Drop</b>                                                        | Primary dentist (prepaid only) <input type="checkbox"/> Current patient <input type="checkbox"/> New patient |               |                                                                  |
| Vision <input type="checkbox"/> <b>Add/keep</b> <input type="checkbox"/> <b>Drop</b>                                                        |                                                                                                              |               |                                                                  |
| Dep. Life <input type="checkbox"/> <b>Add/keep</b> <input type="checkbox"/> <b>Drop</b>                                                     | <input type="checkbox"/> I elect to keep \$ _____ (in \$500 units) of Dependent Life.                        |               |                                                                  |
| <b>Child name</b> <input type="checkbox"/> Medicare eligible                                                                                | SSN                                                                                                          | Date of birth | <input type="checkbox"/> Male<br><input type="checkbox"/> Female |
| Health <input type="checkbox"/> <b>Add/keep</b> <input type="checkbox"/> <b>Drop</b>                                                        | Primary physician (HMO only) <input type="checkbox"/> Current patient <input type="checkbox"/> New patient   |               |                                                                  |
| Dental <input type="checkbox"/> <b>Add/keep</b> <input type="checkbox"/> <b>Drop</b>                                                        | Primary dentist (prepaid only) <input type="checkbox"/> Current patient <input type="checkbox"/> New patient |               |                                                                  |
| Vision <input type="checkbox"/> <b>Add/keep</b> <input type="checkbox"/> <b>Drop</b>                                                        |                                                                                                              |               |                                                                  |
| Dep. Life <input type="checkbox"/> <b>Add/keep</b> <input type="checkbox"/> <b>Drop</b>                                                     | <input type="checkbox"/> I elect to keep \$ _____ (in \$500 units) of Dependent Life.                        |               |                                                                  |

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

## Signatures

|                  |      |
|------------------|------|
| Member signature | Date |
|------------------|------|

I understand that no coverage except vision can be added during the annual Option Period.

- ☐ I authorize EGID to deduct the amount of my premiums from my retirement check according to Administrative Rule 260:50-3-5. (You must verify with your retirement system that your retirement check will cover your premiums.)
- ☐ I request EGID direct bill me for my monthly premiums at the mailing address on this form.

**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 |
|------------------|------|

## Retirement information can be found at [oklahoma.gov/omes](https://oklahoma.gov/omes).

You can carry health, dental, vision and life insurance on yourself and your dependents.

The health, dental and life coverage you take into retiree/vested/non-vested status is the only coverage you can have with EGID through your retirement years. If you do not keep coverage now, you cannot add it later. Plan changes can be made during the annual Option Period.

If you are insuring one dependent, you must insure all eligible dependents (for any given coverage) unless they are covered by other group insurance or Indian or military benefits. Children who have Indian or military benefits or other group insurance may be required to show proof of coverage.

Following your retirement, dependents can be added only within 30 days of one of the following events: birth, adoption or guardianship, marriage or loss of other group insurance.

### DEFER INSTRUCTIONS

If your spouse has separate coverage through EGID at the time you terminate employment, you can transfer your individual health, dental and/or vision coverage to dependent coverage under your spouse's coverage. Your spouse must contact their employer to add you as a dependent. You must elect to transfer coverage within 30 days of your termination of employment. Any 30-day break in coverage voids your eligibility to keep coverage in the future. Life insurance cannot be deferred and must be carried as a primary retiree/vested/non-vested member. When you are ready to return to retiree/vested/non-vested status, you must again complete this form and mark the box on Page 1 of your form to cancel your deferment

### THINGS TO CONSIDER AS A RETIREE WHEN YOU BECOME MEDICARE-ELIGIBLE

**IMPORTANT: If you are under 65 and eligible for Medicare**, you must notify EGID and provide your Medicare number as it appears on your Medicare card. Medicare supplement coverage is effective the date you become eligible for Medicare or the first day of the month following notification of your Medicare eligibility, whichever is later.

When you turn 65, you have the option to enroll in either a Medicare supplement with prescription drug plan or a Medicare Advantage prescription drug plan.

**BCBSOK-BlueSecure and all MAPD plans offered through EGID require you to have both Medicare Part A and Medicare Part B.**

If you are eligible and do not enroll in Medicare Part B, there are two Medicare supplement plans available to you: HealthChoice SilverScript High Option Medicare Supplement Plan and HealthChoice SilverScript Low Option Medicare Supplement Plan. All medical benefits under these plans are paid as if you are enrolled in both Medicare Part A and Part B. If you are not enrolled in Medicare Part B, your plan will estimate Medicare's benefits and provide supplemental coverage as if Medicare is the primary carrier. This means HealthChoice pays secondary and you are responsible for the primary share of the claim.

For information concerning the HMO, MAPD, Medicare supplement, dental or vision plans, contact their customer service numbers.

**For information regarding enrollment or to obtain an application for Medicare supplement plan or MAPD plan, call 405-717-8780 or toll-free 800-752-9475. TTY users call 711.**

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