OKLAHOMA Employees Group Insurance Division

Employees Group Insurance Division

2025 OPTION PERIOD ENROLLMENT/CHANGE FORM

FORMER EMPLOYEES AND SURVIVING DEPENDENTS

If not making changes, do not return this form. All changes are effective Jan. 1, 2025

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**

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

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**

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

*Must complete online Tobacco-Free Attestation or reasonable alternative by Dec. 31, 2024.

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

☐ Current patient ☐ New patient

Dental plan election – Select a plan to change

☐ **No change** ☐ **Change** ☐ **Drop**

☐ 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

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**

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

Member Life plan election (decreasing is in $5,000 units)

☐ **No change** ☐ **Drop** ☐ **Decrease total 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

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

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

If making changes, return completed form(s) no later than Dec. 7, 2024, to:

EGID
P.O. Box 11137
Oklahoma City, OK 73136-9998