Oklahoma State & Education Employees Group Insurance Program
INSURANCE CHANGE FORM

EMPLOYER INFORMATION (should be completed by Insurance Coordinator)

Group ID#: _____ **Division ID#:** _____ **Group Name:** _____

EMPLOYEE INFORMATION

Social Security # _____-_____-_____ ☐ Married ☐ Single

Employee's Name Please Print	First Name	M. Init.	Last Name

☐ Legal Name Change From: _____ To: _____

Mailing Address (if changed): _____
STREET

_____
CITY STATE ZIP CODE

Home Telephone # (___)_____ E-Mail Address:_____ Worksite Zip Code:_____

Effective Date Of This Form	Mo.		Day		Yr.	
			0	1		

HEALTH PLAN ELECTION

			EMPLOYEE COVERAGE	
			ADD	DROP
Aetna HMO ☐ Standard ☐ Alternative	**CommunityCare HMO** ☐ Standard ☐ Alternative	**GlobalHealth HMO** ☐ Standard ☐ Alternative		
PacifiCare HMO ☐ Standard ☐ Alternative	**HealthChoice** ☐ High ☐ Basic	☐ **TRICARE Supplement/ASI**	☐	☐

Employee Primary Physician (HMO Only): _____ Premium:_____

☐ Current Patient ☐ New Patient

DENTAL PLAN ELECTION

☐ **Assurant Heritage Plus Prepaid**	☐ **CIGNA Dental Prepaid Plan**	☐ **Delta's Choice PPO**	☐	☐
☐ **Assurant Freedom Preferred**	☐ **HealthChoice**	☐ **Delta's Dental PPO-POS**		

Employee Primary Dentist (Prepaid Only): _____ Premium:_____

☐ Current Patient ☐ New Patient

VISION PLAN ELECTION

☐ **CompBenefits/Vision Care Plan**	☐ **Spectera Vision**	☐ **Vision Service Plan**	☐	☐
☐ **Primary Vision Care Services**	☐ **Superior Vision Plan**			

Premium:_____

LIFE INSURANCE ELECTIONS

Basic and Supp Life can only be added at Initial Enrollment, at Option Period, or within thirty (30) days of loss of other group life insurance with proof of loss. Your Supp Life Guaranteed Issue (GI), is equal to two (2) times your yearly salary rounded up to the next $20,000 increment. The maximum amount of Supplemental Life insurance you can have in force at any time is equal to five (5) times your yearly salary rounded up to the next $20,000 increment not to exceed $300,000.

Amounts requested over your GI require completion of a separate Life Insurance w/ EOI (Evidence Of Insurability) form.

ADD	DROP		
☐	☐	**BASIC LIFE(required for supplemental life)**	$ 20,000.00
☐	☐	**SUPPLEMENTAL LIFE** (indicate the amount you wish to carry in $20,000 increments)	$_____
		TOTAL EMPLOYEE LIFE INSURANCE REQUESTED (Basic + Supplemental)	$_____

ADD	DROP		
☐	☐	**Dependent Life High Option** (Spouse = $10,000, Each Child = $5,000, Birth to 6 mos = $1,000)	
☐	☐	**Dependent Life Low Option** (Spouse = $6,000, Each Child = $3,000, Birth to 6 mos = $1,000)	

FOR OSEEGIB USE ONLY

Revised 11-09-05

DEPENDENT INFORMATION

ADD **DROP**

SPOUSE: ☐ ☐ HEALTH NAME: ______________________ SSN: ______________

☐ ☐ DENTAL DATE OF BIRTH: ______________ DATE OF DEATH: ______________

☐ ☐ VISION ADDRESS (☐ Check if same as employee): ______________________

☐ ☐ DEP LIFE ______________________

Primary Physician: ______________________ Primary Dentist: ______________________

☐ **Current Patient** ☐ **New Patient** ☐ **Current Patient** ☐ **New Patient**

Does your Spouse currently have health, dental, or vision coverage through OSEEGIB? ☐ **Yes** ☐ **No (If Yes, list Name and SSN above)**

ADD **DROP**

CHILD: ☐ ☐ HEALTH NAME: ______________________ SSN: ______________

☐ ☐ DENTAL DATE OF BIRTH: __________ DATE OF DEATH: __________ ☐ MALE ☐ FEMALE

☐ ☐ VISION ADDRESS (☐ Check if same as employee): ______________________

☐ ☐ DEP LIFE Age 19-25 and Full Time Student? ☐ Yes ☐ No

Primary Physician: ______________________ Primary Dentist: ______________________

☐ **Current Patient** ☐ **New Patient** ☐ **Current Patient** ☐ **New Patient**

ADD **DROP**

CHILD: ☐ ☐ HEALTH NAME: ______________________ SSN: ______________

☐ ☐ DENTAL DATE OF BIRTH: __________ DATE OF DEATH: __________ ☐ MALE ☐ FEMALE

☐ ☐ VISION ADDRESS (☐ Check if same as employee): ______________________

☐ ☐ DEP LIFE Age 19-25 and Full Time Student? ☐ Yes ☐ No

Primary Physician: ______________________ Primary Dentist: ______________________

☐ **Current Patient** ☐ **New Patient** ☐ **Current Patient** ☐ **New Patient**

ADD **DROP**

CHILD: ☐ ☐ HEALTH NAME: ______________________ SSN: ______________

☐ ☐ DENTAL DATE OF BIRTH: __________ DATE OF DEATH: __________ ☐ MALE ☐ FEMALE

☐ ☐ VISION ADDRESS (☐ Check if same as employee): ______________________

☐ ☐ DEP LIFE Age 19-25 and Full Time Student? ☐ Yes ☐ No

Primary Physician: ______________________ Primary Dentist: ______________________

☐ **Current Patient** ☐ **New Patient** ☐ **Current Patient** ☐ **New Patient**

PLEASE USE THE DEPENDENT ATTACHMENT FORM TO LIST ADDITIONAL DEPENDENTS

(This form is available from your Insurance Coordinator)

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

Employee Signature: ______________________ Date: ______________

SPOUSE MUST SIGN IF SPOUSE IS COMMON LAW OR EXCLUDED FROM HEALTH OR DENTAL COVERAGE

☐ **COMMON LAW SPOUSE CERTIFICATION:** I certify that the person listed as my spouse and I have an actual and mutual agreement between ourselves to be husband and wife; that this is a permanent relationship; and that our relationship is exclusive, as proven by our cohabitation as man and wife; and do hereby hold ourselves out publicly as husband and wife. **I am aware that this relationship can only be dissolved by legal divorce.**

☐ **SPOUSE EXCLUSION CERTIFICATION:** I certify that I am aware **I am being excluded from Health and/or Dental 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 his/her spouse until either the next option period or a change of status event occurs. **(Needed only if children are covered and spouse is not.)**

Spouse's Signature: ______________________ Date: ______________

I certify that this change 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 mid-year coverage changes as defined by Title 26, Section 125, of the Internal Revenue Codes (as amended), and pertinent regulations. I further certify that this employee's yearly salary listed below (if required) is correct to the best of my knowledge on this date.

(Must be signed by Insurance Coordinator to be valid)

Employee's Yearly Salary (Required for Supplemental Life in excess of $20,000): $______________

Insurance Coordinator Signature: ______________________ Date: ______________

PLAN GUIDELINES FOR ELECTION CHANGES

Detach and retain for your Records

IMPORTANT – YOU MUST READ THE FOLLOWING PLAN GUIDELINES BEFORE COMPLETING FORM
Signatures on your form certify that you have read this page and that all of your elections meet the plan Guidelines.
Refer to Title 74 Oklahoma Statutes §1323, Fraud - Penalties

Changing or adding coverage for yourself and your dependents:

Mid-Year Changes: To be eligible to add, drop, or change coverage on yourself and/or your dependents subsequent to your initial employment (other than Option Period), you must have experienced a Qualifying Event and, you must make your elections and sign the form within 30 days of the Qualifying Event.

Strict consistency rules apply to all Qualifying Events. A benefit election change is only consistent with a Qualifying Event if the election changes are necessary or appropriate as a result of the event, i.e. adding Health coverage (benefit election change) is NOT consistent with the loss of a dependent child (Qualifying Event.) **Allowable Mid-Year Changes within Plan guidelines include:**

- Change in your legal marital status
- Change in your number of dependents
- Change in your, or your dependents employment status that directly effects eligibility
- An event that causes your dependent to satisfy, or cease to satisfy eligibility requirements (over age limit, student status, etc.)
- Changes in your, or your dependents, place of residence that directly effects eligibility or HMO/DMO availability
- Leaving on or returning from FMLA Leave, Leave Without Pay, USERRA Leave, Disability Leave

Changes that do not fall into the above categories are generally not allowed except at Option Period. If in doubt as to whether you qualify for a change, please contact your Insurance Coordinator.

If you declined member or dependent life coverage in the Plan because of having other group life coverage through a source other than the participating entity, you may request coverage (up to the amount lost, rounded up to the next $20,000 increment) under the Plan within thirty (30) days of loss of the other group life coverage. Your request must be accompanied by proof of loss of other group life coverage that indicates the date of loss and amount of coverage. Evidence of Insurability is not required if coverage is requested within this 30 day period.

You must already be enrolled in at least Basic Life and have a Qualifying Event in order to add your dependents to Dependent Life.

Dropping coverage for yourself or your dependents:

Any coverage that is dropped cannot be reinstated for 12 months (unless you experience a qualifying event). After 12 months you may regain coverage (if requested within 30 days of the end of the 12 month period), but you will be subject to preexisting conditions and/or dental limitations.

You must elect health coverage in order to be eligible for Dental and/or Life coverage through the Oklahoma State and Education Employees Group Insurance Board. You may exclude health coverage if you have other verifiable group health coverage. You may be asked to provide proof of that coverage. Failure to provide proof when requested will result in termination of all coverage.

To be eligible for coverage, a child must be unmarried and under the age of 19. A child who is over age 19, but is a full-time student may be covered up to age 25 as long as he retains full-time student status. **It is your responsibility to notify your Insurance Coordinator when your child is no longer a student, marries, or otherwise becomes ineligible.** The State and Education Employees Group Insurance Board will not pay claims on ineligible dependents even if you have paid premiums for that dependent.

Your dependents are not eligible for any coverage in which you are not enrolled.

If you cover one child for any given benefit, you must cover all of your children for that benefit. You may only exclude children who have verifiable other group coverage and you may be asked to provide proof of that coverage. Failure to provide proof when requested will result in disqualification of your covered dependents.

You may cover your children and exclude your spouse from Health and/or Dental. If you choose this option, your spouse must sign and date this form under the Certification Signature.

You may cover your children and exclude your spouse from Vision and/or Life coverage, only if your spouse has other verifiable group Vision and/or 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.

(CONTINUED ON BACK)

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

Notification time limits:

The following deadlines for submitting this form to the Oklahoma State and Education Employees Group Insurance Board are strictly enforced. Forms not received within the specified time period will not be processed.

Mid-year Changes – must be received by the Board within 40 days of the qualifying event.

Confirmation Statement – When you make changes to your coverage you will be provided a Confirmation Statement (CS). The CS identifies your coverage changes, the effective date of the change and the premium amounts applicable to the changes. The CS allows you to review the changes to your coverage so that any error can be identified and corrected. Corrections should be submitted to your Insurance Coordinator or the Board within 60 days of the election. Corrections reported to your IC or the Board after 60 days will be effective the first of the month following notification.

Oklahoma State and Education Employees Group Insurance Board (OSEEGIB) Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OSEEGIB is a State of Oklahoma governmental agency that is created and governed by Oklahoma law for the purpose of administering health, life, disability, and dental benefits to state, local government, and education employees, and other groups designated by statute, including each of the preceding groups' respective retirees. Oklahoma privacy laws and the federal Health Insurance Portability and Accountability Act (HIPAA) govern privacy matters between OSEEGIB and its participants concerning the privacy of identifiable health information. Information contained in an OSEEGIB member's file is confidential by law and we at OSEEGIB are committed to protecting this information.

This notice describes and gives you examples of the permitted ways your health information may be used and disclosed.

OSEEGIB uses and discloses your protected health information for your treatment, payment for services, and OSEEGIB business operations in the administration of health plans. The health claims you submit, or health claims submitted by providers for your treatment, contain protected health information and are processed for payment and data collection by claims administrators according to Oklahoma law and contractual terms of confidentiality with OSEEGIB. Your health information is used and disclosed by OSEEGIB employees and other entities under contract with OSEEGIB according to the 'minimum necessary' standard. OSEEGIB or its claims administrators may use and disclose health information, to determine medical necessity for pre-certification of hospital and medical benefits, case management, approval for supplemental life insurance, grievance matters, premium rate setting, required disease management programs, law enforcement, public health threats, workers' compensation/disability, national security, and as required by law. OSEEGIB will ask for your written permission before it uses or discloses your health information for purposes that are not described in this Notice.

You have the right to: a) inspect and copy your health information (generally EOBs) with the exception of psychotherapy notes and / or information that requires a court order; b) amend and restrict the health information that OSEEGIB discloses about you; however, OSEEGIB is not required to agree to a requested restriction; c) request your communications remain confidential with OSEEGIB; d) receive a copy of this Notice; e) file a complaint if you believe OSEEGIB has improperly used or disclosed your information; f) request a listing of disclosures, except for treatment, payment, business operations, and per your Authorization after April 14, 2003; and, g) receive a paper copy of this Notice upon request if you have received this Notice electronically.

OSEEGIB reserves the right to change the terms of this Privacy Notice and will provide all interested persons a revised notice either by U.S. Postal Service delivered to the individual's mailing address on file with OSEEGIB or electronic communication by posting the revised Privacy Notice on the OSEEGIB website at www.healthchoiceok.com and www.sib.ok.gov

If you believe your privacy rights have been violated, call or send a written complaint to the OSEEGIB HIPAA Information Officer at 3545 NW 58th, Suite 110, Oklahoma City, Oklahoma 73112, (405) 717-8701, Toll-free (800) 752-9475, TDD (405) 949-2281, Toll-free TDD (866) 447-0436, the Secretary of the U. S. Department of Health and Human Services (HHS) at the Office of Civil Rights, 1301 Young Street, Suite 1169, Dallas, Texas 75202 (214) 767-4056, or submit an electronic complaint according to directions located on the HHS Office of Civil Rights website. Complaints to HHS must be filed within 180 days after the date on which you became aware, or should have been aware, of the violation. No retaliation is allowed against the individual filing a complaint.

Revised Notice 8/5/05

The administration of the Oklahoma State and Education Employees Group Insurance Board is dictated by state statute and agency Rules. You may view the entire text of the Rules governing OSEEGIB at our website: www. healthchoiceok.com.