Oklahoma State & Education Employees Group Insurance Program
INSURANCE ENROLLMENT FORM

EMPLOYER INFORMATION (SHOULD BE COMPLETED BY INSURANCE COORDINATOR)

Group ID#: ________________________ **Division ID#:** _______________ **Group Name:** __________________________________

☐ **New Hire Enrollment** ☐ **Mid-Year Enrollment**

EMPLOYEE INFORMATION

Social Security # ______________-________-________________ ☐ Married ☐ Single

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

Mailing Address ____
STREET

____
CITY STATE ZIP CODE

Home Telephone # (____)__________________ E-Mail Address:______________________ Worksite Zip Code:______________

Employee's Birth Date	Mo.		Day		Yr.		Sex
							☐M ☐F

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

If you are transferring from another participating entity, are you willing to accept a break in coverage? ☐ Yes ☐ No
If no, please contact your Insurance Coordinator to arrange payment of premiums (if necessary) to prevent a break.
(Please see attached Guidelines under "Pre-existing Condition Limitation" for explanation)

HEALTH PLAN ELECTION

HealthChoice ☐ **High** ☐ **Basic**
Aetna HMO ☐ **Standard** ☐ **Alternative**
CommunityCare HMO ☐ **Standard** ☐ **Alternative**
GlobalHealth HMO ☐ **Standard** ☐ **Alternative**
PacifiCare HMO ☐ **Standard** ☐ **Alternative**

☐ **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 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. 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.

☐ **BASIC LIFE** **(required for supplemental life)** $ **20,000**

☐ **SUPPLEMENTAL LIFE** (If more than Guaranteed Issue, requires EOI) (in $20,000 increments) $__________________

TOTAL EMPLOYEE LIFE INSURANCE REQUESTED (Basic + Supplemental) $__________________

☐ **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)**

☐ HEALTHCHOICE DISABILITY (Available to certain County Employers ONLY)

FOR OSEEGIB USE ONLY

Revised 11/09/05

DEPENDENT INFORMATION

SPOUSE: ☐ HEALTH NAME: ______________________ SSN: ______________

☐ DENTAL DATE OF BIRTH: ______________________

☐ 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)**

CHILD: ☐ HEALTH NAME: ______________________ SSN: ______________

☐ DENTAL DATE OF BIRTH: ______________ ☐ 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**

CHILD: ☐ HEALTH NAME: ______________________ SSN: ______________

☐ DENTAL DATE OF BIRTH: ______________ ☐ 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**

CHILD: ☐ HEALTH NAME: ______________________ SSN: ______________

☐ DENTAL DATE OF BIRTH: ______________ ☐ 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 ADD MORE 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 Insurance Enrollment. 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 enrollment is in compliance with the provisions of the employer's Section 125 Plan or, if no 125 Plan is offered, are in compliance with new hire or allowed mid-year coverage enrollments 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 INSURANCE ENROLLMENT

Detach and Retain For Your Records

IMPORTANT – YOU MUST READ THE FOLLOWING 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

Enrolling yourself and your dependents:

New Hire Enrollments: You may enroll yourself and your dependents in any or all coverage. You must make your elections and sign the form within 30 days of your Entry-on-Duty Date.

Subsequent Mid Year Enrollments: To be eligible for enrollment after your initial employment (other than Option Period), you must have lost other verifiable group coverage. You may only enroll yourself and your dependents in the specific coverage that was lost. You must make your elections and sign the form within 30 days of the Qualifying Event (the date the loss occurred.)

Supersede Enrollment: You have 30 days following your Entry-on-Duty Date to make any additions or changes to the coverage you have elected. In order to make changes, you must submit a new enrollment form with "SUPERSEDE" written across the top. This will alert OSEEGIB that no qualifying event is necessary due to the change being made within 30 days of your Entry-on-Duty Date. Any changes you make to your original coverage will be effective the first day of the month following the date you sign the "supersede" form.

Pre-existing Condition Limitation: This limitation is applied to HealthChoice medical coverage when a break in coverage of one or more days occurs between the last day of previous medical coverage and the Effective Date of HealthChoice coverage. The Pre-existing Condition Limitation is defined as: "conditions for which you were previously treated during the six months prior to your effective date, will not be covered for the first six months following your effective date."

If you do not have continuous group coverage for yourself and your dependents, your coverage is subject to a preexisting condition limitation. In order to waive the preexisting condition limitation, you may supply proof of continuous coverage along with this enrollment form.

Elections:
You must elect health coverage in order to be eligible for Dental and 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, you must cover all of your children. 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.

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

You must enroll in Basic Life in order to enroll in Supplemental Life and/or enroll your dependents in Dependent Life.

When you enroll you will be provided a Confirmation Statement (CS). The CS identifies your enrollment elections, the effective date of coverage and the premium amounts applicable to the enrollment. The CS allows you to review the enrollment 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.

(CONTINUED ON BACK)

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 periods will not be processed.

New hire enrollment – must be received by the Board within 40 days of your initial employment date.
Subsequent Mid-year election enrollment – must be received by the Board within 40 days of the qualifying event.

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.