Employee Benefits Department of HCM Plan Year 2013

Enrollment Form

Current Plan Year Ending: December 31, 2012
Next Plan Year begins: January 1, 2013 and ends December 31, 2013
Pay Frequency _____ (Monthly, Biweekly)
Agency _____
Employee ID _____
Employee Name _____
Birthdate _____
Address _____
_____

Section A (For Enrollment)

Premium Conversion

Next Plan Year Choice: ☐ **Yes** ☐ **No***

** No = No tax savings on eligible premiums*

Health Plan Election

Next Plan Year Choice:

- ☐ **CommunityCare**
- ☐ **GlobalHealth**
- ☐ **HealthChoice High**
- ☐ **HealthChoice Basic**
- ☐ **HealthChoice High Alternative**
- ☐ **HealthChoice Basic Alternative**
- ☐ **HealthChoice S-Account**

**List PCP only if you are switching to an HMO or changing HMOs for January 1.*
Employee PCP for HMO: _____
(If spouse or child's PCP is different or if adding or dropping dependents, indicate on section B)

Dental Plan Election

Next Plan Year Choice:

- ☐ **HealthChoice Dental**
- ☐ **Assurant Heritage Plus***
- ☐ **CIGNA Dental Prepaid***
- ☐ **Delta PPO**
- ☐ **Assurant Freedom**
- ☐ **Assurant Heritage Secure***
- ☐ **Delta Choice**
- ☐ **Delta Premier**

*** List Employee PCD:** _____
(If spouse or child's PCD is different, indicate on section B)

Vision Plan Election

Next Plan Year Choice:

- ☐ **NO CHANGE**
- ☐ **DROP ALL**
- ☐ **CHANGE**
- ☐ **Employee**
- ☐ **Dependents** *(Must name dependents on Section B)*
- ☐ **Humana**
- ☐ **PVCS**
- ☐ **United HealthCare Vision**
- ☐ **Superior**
- ☐ **VSP**

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Supplemental Life

Next Plan Year Choice: ☐ **NO CHANGE** ☐ **DROP ALL** ☐ **CHANGE $ _____ Amount**

(To reduce or increase ask your Benefits Coordinator for required forms)

Dependent Life *(For family members*)*

Next Plan Year Choice: ☐ **NO CHANGE** ☐ **DROP ALL** ☐ **CHANGE**

Choose: ☐ **PREMIER OPTION** ☐ **STANDARD OPTION** ☐ **LOW OPTION**

**Must name dependents on Section B for coverage*

Flexible Spending Account *(Current participants must re-enroll to continue coverage and use of debit card)*

Next Plan Year Choice: ☐ **Enroll for FREE Debit Card** *(By using the card you hereby renew your My Use of Card Promises included with your card)*

Health Care Account *(Enrollment not available if electing HealthChoice S-Account)*

☐ **None** **$ _____ (per pay period)** **$ _____ (per plan year)**

Dependent Daycare Account

☐ **None** **$ _____ (per pay period)** **$ _____ (per plan year)**

☐ **Opt out of Core Benefits (Health, Dental, Disability or Base Life), including any Supplemental Life or Dependent Life (Requires an Opt-out form)**

MILITARY RETIREES ONLY: I am an eligible retired military state employee, and I understand I can choose to participate in the basic plan of benefits, or elect to opt out of all required benefits for myself and all dependents for this Plan Year. I am making my choice below. I understand if I am completely opting out of benefits, I must submit a copy of my "DD Form 2 Retired" form as well as complete additional forms to give effect to my choices. You must see your Benefit Coordinator for applicable forms.

☐ **Opt out of all core benefits**

☐ **Elect Tricare Supplement**

IMPORTANT: PLEASE READ AND SIGN.

I hereby authorize and agree to a salary reduction, if necessary, to implement my benefits elections. I understand that my benefit elections are binding, irrevocable, and effective for the entire Plan Year unless I experience an allowable midyear change. I further understand that I must notify the Employees Benefits Department of HCM within 30 days after a midyear change to give effect to the change. The elections I now submit revokes and supersedes all previous benefit elections. I understand any remaining funds in the spending accounts after the end of the Plan Year will be forfeited upon my termination with the State.

Employee Signature: _____ **Date:** _____

Section B (Dependents/options to be added or dropped)

1. Do NOT list dependents currently covered under Health, Dental, Vision and Dependent Life, if you wish to keep them covered for the new Plan Year. The system will roll prior dependent elections over into the 2013 Plan Year. Only list dependents you want to ADD or DROP from health, dental, vision, and dependent life.
2. Do NOT list a PCP unless you are switching to an HMO or changing HMOs for the new plan year.
3. Do NOT list a PCD unless you are switching to a Prepaid Dental Plan.

For all midyear changes to PCP or PCD, call the HMO or Dental Plan.

Spouse: **Health:** ___ Add ___ Drop **Dental:** ___ Add ___ Drop **Vision:** ___ Add ___ Drop **Dependent Life:** ___ Add ___ Drop	Name _____ Date of Birth_____ Social Security Number _____ _____ Male _____Female Address _____ _____ Primary Care Physician (PCP) _____ Primary Care Dentist (PCD) _____
Child: **Health:** ___ Add ___ Drop **Dental:** ___ Add ___ Drop **Vision:** ___ Add ___ Drop **Dependent Life:** ___ Add ___ Drop	Name _____ Date of Birth_____ Social Security Number _____ _____ Male _____Female Address _____ _____ Primary Care Physician (PCP) _____ Primary Care Dentist (PCD) _____
Child: **Health:** ___ Add ___ Drop **Dental:** ___ Add ___ Drop **Vision:** ___ Add ___ Drop **Dependent Life:** ___ Add ___ Drop	Name _____ Date of Birth_____ Social Security Number _____ _____ Male _____Female Address _____ _____ Primary Care Physician (PCP) _____ Primary Care Dentist (PCD) _____
Child: **Health:** ___ Add ___ Drop **Dental:** ___ Add ___ Drop **Vision:** ___ Add ___ Drop **Dependent Life:** ___ Add ___ Drop	Name _____ Date of Birth_____ Social Security Number _____ _____ Male _____Female Address _____ _____ Primary Care Physician (PCP) _____ Primary Care Dentist (PCD) _____
Other: **Health:** ___ Add ___ Drop **Dental:** ___ Add ___ Drop **Vision:** ___ Add ___ Drop **Dependent Life:** ___ Add ___ Drop	Name _____ Date of Birth_____ Social Security Number _____ _____ Male _____Female Address _____ _____ Primary Care Physician (PCP) _____ Primary Care Dentist (PCD) _____

Enroll in FREE Health Mentoring Program for State Employees.
VISIT www.ebc.state.ok.us/en/OKHealth