EMPLOYEE BENEFITS DEPARTMENT OF HCM
of the Office of Management and Enterprise Services

New Hire Form

Employee Information Please Print or Type	SSN		Payroll ID
Last Name	First Name	Middle Initial	Email
Home Mailing Address	City	State	Zip
Home Phone ( )	Date of Birth	☐ Married ☐ Single	☐ M ☐ F

Hiring Agency	Agency Name	Agency #/Location Code	Work Phone ( )
Date Employed / /	Effective Date / 01 /		Pay Frequency ☐ 12 ☐ 24 ☐ 26

Premium Conversion	Provides tax savings on eligible premiums. Enrollment is automatic unless you check the "NO" box. **Available for All.**	☐ No = All Premiums taxed

Active Opt Out	Active Employees may opt out of the "Basic Plan" (Life, Disability, Health and Dental), or Health and Dental insurance only, if the employee is currently covered under another group insurance plan. The employee must provide required documentation of group coverage and attach to this form. See Benefit Coordinator for form and information.	Basic Plan ☐	Health and Dental ☐
Retired Military	Retired Military may opt out of some or all coverage but must complete the Opt Out Acceptance Form, provide required documentation, and attach to this form. See Benefits Coordinator for form and information.	Basic Plan ☐	Health and Dental ☐

Health Insurance	Plan Name & Option Level	Authorized Zip
HMO applicants select Primary Care Physician		

Dental Insurance	Plan Name	DMO applicants select Primary Care Dentist

Vision Insurance Available for All	☐ Employee Only ☐ Employee & Family ☐ None	Plan Name

Supplemental Life Insurance

Annual Salary $_____

Basic & Supp Life can only be added as a New Hire employee, during Option Period, or within thirty (30) days after losing other group life insurance. The Supplemental Life Guaranteed Issue (GI) amount can be up to two (2) times your yearly salary, rounded up to the next $20,000 increment. The maximum Supplemental Life Insurance allowed [including guaranteed issue], may not exceed $500,000.
Amounts requested over your GI require completion of a separate Life Insurance Application Form.

☒ Basic (required)	$ 20,000.00
☐ Guaranteed Issue (up to 2x annual salary at time of employment)	$ _____
☐ Supplemental Life AGI	$ _____
TOTAL	$ 20,000.00

Dependent Life Insurance	☐ Yes ☐ No	If Yes, Select Option ☐ Premier ☐ Standard ☐ Low

Flexible Spending Accounts (Available for All)

☐ Enroll for FREE Debit Card (only for use with Flexible Spending Accounts)

		Pay Period	None
☐ Dependent Care Account	Monthly minimum=$50, Monthly maximum = $416.66	$ _____	☐
☐ Health Care Account	Monthly minimum=$10, Monthly maximum = $208.33	$ _____	☐

Employee Authorization

I authorize and agree to any NECESSARY salary reduction to implement my elections. I UNDERSTAND MY ELECTIONS ARE BINDING AND IRREVOCABLE AND WILL REMAIN IN EFFECT FOR THE FULL PLAN YEAR UNLESS I EXPERIENCE AN ALLOWABLE MIDYEAR CHANGE EVENT. I understand that I have 30 days from the event to request any applicable changes to my options for this Plan Year. I also understand that any money left in the reimbursement account(s) will be forfeited at the end of the Plan Year grace period or upon my termination with the State.

Employee Signature	**Date**	**Agency#**	**Location#**
_____	_____	_____ /	_____

SSN#

Dependent Information

Spouse

- ☐ **Add Health**
- ☐ **Add Dental**
- ☐ **Add Vision**
- ☐ **Add Dep Life**

Name		SSN	
Date of Birth	☐ M ☐ F		
Address	City	State	Zip
Primary Care Physician			
Primary Care Dentist			

Child

- ☐ **Add Health**
- ☐ **Add Dental**
- ☐ **Add Vision**
- ☐ **Add Dep Life**

Name		SSN	
Date of Birth	☐ M ☐ F		
Address	City	State	Zip
Primary Care Physician			
Primary Care Dentist			

Child

- ☐ **Add Health**
- ☐ **Add Dental**
- ☐ **Add Vision**
- ☐ **Add Dep Life**

Name		SSN	
Date of Birth	☐ M ☐ F		
Address	City	State	Zip
Primary Care Physician			
Primary Care Dentist			

Are you or any of your dependents covered under other group coverage? ☐ Yes ☐ No

☐ OK State	☐ Education	☐ County	Organization Name (Self)	Final Employment Date
☐ OK State	☐ Education	☐ County	Organization Name (Spouse)	

Declining Coverage for Dependents

If you are declining enrollment for your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll your dependents in this plan if your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependents' other coverage). However, you must request enrollment within thirty (30) days after your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your dependents. However, you must request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact your agency's Benefits Coordinator.

Employee Signature Date

X _____ _____

My signature above represents that I am declining health coverage on my eligible dependents.

Benefits Coordinator Authorization, please date & sign.

This original enrollment form must be sent to the Employees Benefits Department of HCM with any additional required enrollment documentation (i.e. Exclusion for Spouse Coverage, other group coverage proof, Life Insurance Applications, etc.). An incomplete form (by employee or Coordinator) will be returned resulting in a processing delay and/or denial of claims.

Benefits Coordinator Phone Date

X _____ (____) _____ _____

BC Email

_____

IMPORTANT! Send Original form and all attachments to the Employees Benefits Department of HCM

New Hire

Print Form with Information | Clear Form