



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

Newly Eligible Form

(Previously New Hire Form)

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|--------------------------------------------------|---------------|----------------------------------|---------------------------------|-------------------------------------------------------|
| 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 | <input type="checkbox"/> Married | <input type="checkbox"/> Single | <input type="checkbox"/> M <input type="checkbox"/> F |

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|----------------------|-----------------------|---------------------------------------------------------------------------------------------------|----------------|
| Hiring Agency | Agency Name | Agency #/Location Code | Work Phone () |
| Date Employed / / | Effective Date / 01 / | Pay Frequency <input type="checkbox"/> 12 <input type="checkbox"/> 24 <input type="checkbox"/> 26 | |

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| Premium Conversion | Provides tax savings on eligible premiums. Enrollment is automatic unless you check the "NO" box. Available for All. | <input type="checkbox"/> No = All Premiums taxed |
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| 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 <u>group insurance plan</u> . The employee must provide required documentation of coverage, or Tricare coverage and a copy of the DD2 Retirement Card, and attach to this form. See Benefit Coordinator for form and information. | Basic Plan <input type="checkbox"/> | Health and Dental <input type="checkbox"/> |
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| Health Insurance | Plan Name & Option Level | Authorized Zip |
| HMO applicants select Primary Care Physician | | |

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| Dental Insurance | Plan Name | DMO applicants select Primary Care Dentist |
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| Vision Insurance Available for All | <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Family <input type="checkbox"/> None | Plan Name |
|----------------------------------------------|-----------------------------------------------------------------------------------------------------------------|-----------|

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| Supplemental Life Insurance | Annual Salary \$ _____ | <input type="checkbox"/> Basic (required) | \$ _____ |
| 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. | | <input type="checkbox"/> Guaranteed Issue (up to 2x annual salary at time of employment) | \$ _____ |
| | | <input type="checkbox"/> Supplemental Life AGI | \$ _____ |
| | TOTAL | | \$ _____ |

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| Dependent Life Insurance | <input type="checkbox"/> Yes <input type="checkbox"/> No | If Yes, Select Option <input type="checkbox"/> Premier <input type="checkbox"/> Standard <input type="checkbox"/> Low |
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| Flexible Spending Accounts (Available for All) | <input type="checkbox"/> Enroll for FREE Debit Card (only for use with Flexible Spending Accounts) | Annual Election |
| <input type="checkbox"/> Dependent Care Account | Annual minimum=\$600, Annual maximum = \$5,000 | _____ |
| <input type="checkbox"/> Health Care Account | Annual minimum=\$120, Annual maximum = \$2,500 | _____ |

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| 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 <input type="checkbox"/> Add Health <input type="checkbox"/> Add Dental <input type="checkbox"/> Add Vision <input type="checkbox"/> Add Dep Life | Name | SSN | |
| | Date of Birth | <input type="checkbox"/> M <input type="checkbox"/> F | |
| | Address | City | State Zip |
| | Primary Care Physician | | |
| | Primary Care Dentist | | |

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|-------------------------------------------------------|-----------|
| Child <input type="checkbox"/> Add Health <input type="checkbox"/> Add Dental <input type="checkbox"/> Add Vision <input type="checkbox"/> Add Dep Life | Name | SSN | |
| | Date of Birth | <input type="checkbox"/> M <input type="checkbox"/> F | |
| | Address | City | State Zip |
| | Primary Care Physician | | |
| | Primary Care Dentist | | |

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|-------------------------------------------------------|-----------|
| Child <input type="checkbox"/> Add Health <input type="checkbox"/> Add Dental <input type="checkbox"/> Add Vision <input type="checkbox"/> Add Dep Life | Name | SSN | |
| | Date of Birth | <input type="checkbox"/> M <input type="checkbox"/> F | |
| | Address | City | State Zip |
| | Primary Care Physician | | |
| | Primary Care Dentist | | |

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| Are you or any of your dependents covered under other group coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Final Employment Date |
| <input type="checkbox"/> OK State <input type="checkbox"/> Education <input type="checkbox"/> County | Organization Name (Self) | | |
| <input type="checkbox"/> OK State <input type="checkbox"/> Education <input type="checkbox"/> County | Organization Name (Spouse) | | |

| Declining Coverage for Dependents | |
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| <p>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.</p> | |
| Employee Signature | Date |
| X _____ | _____ |
| My signature above represents that I am declining health coverage on my eligible dependents. | |

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| Benefits Coordinator Authorization, please date & sign. | | |
| <p>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.</p> | | |
| Benefits Coordinator | Phone | Date |
| X _____ | (____) _____ | _____ |
| BC Email | _____ | |
| IMPORTANT! Send Original form and all attachments to the Employees Benefits Department of HCM | | |