Employee Benefits Department of HCM Plan Year 2016

Option Period Enrollment Form

Current Plan Year Ending: December 31, 2015
Next Plan Year begins: January 1, 2016 and ends December 31, 2016
Pay Frequency _____ (Monthly, Biweekly)
Agency _____
Employee ID _____
Social Security Number _____
Employee Name _____
Birthdate _____
Address _____
☐ Change _____

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:

- ☐ **Aetna**
- ☐ **BlueLincs HMO**
- ☐ **CommunityCare – Tulsa & Surrounding Counties**
- ☐ **GlobalHealth**
- ☐ **HealthChoice High**
- ☐ **HealthChoice Basic**
- ☐ **HealthChoice High Alternative**
- ☐ **HealthChoice Basic Alternative**
- ☐ **HealthChoice HDHP**

**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 Plus 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**
- ☐ **VisionCare Direct**

Employee Benefits Department of HCM Plan Year 2016

Option Period Enrollment Form

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 HDHP Account)*

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

Dependent Daycare Account

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

Health Savings Account *(To be used with the High Deductible Health Plan)*

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

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

☐ **Elect Tricare Supplement**

☐ **Opt out of all core benefits** ☐ **Opt out of health and dental only**

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 2016 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) _____