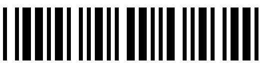


Employees Benefits Council Plan Year 2012

""""""""""""""Enrollment Form

Current Plan Year Ending: December 31, 201F

Next Plan Year begins: January 1, 201Gand ends December 31, 201G

Pay Frequency___________({ [}c@ Ëä ^^\|ˆ)

Agency ´´´

Employee ID ´´´´´´´´´´´´´´´´´´´´´´´´´´´´´´´´´´´´´
Á

Employee Name´´´´´´´´´´´´´´´´´´´´´´´´´´´´´´´´´´´´

Birthdate ´´

Address_______________________________________

ÁÁÁÁÁÁÁÁÁÁÁÁÁ ´´

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 Standard*	**CommunityCare Alternative***	**CommunityCare Wellness Alternative***
GlobalHealth Standard*	**GlobalHealth Alternative***	**GlobalHealth Wellness Alt + ***
HealthChoice High	**HealthChoice High Alternative**	**HealthChoice S-Account**
HealthChoice Basic	**HealthChoice Basic Alternative**	
United Healthcare Standard*	**United Healthcare Alternative***	**United Healthcare Wellness Alt + ***

If Wellness Alt. Plan is chosen an HRA is required. See enrollment guide for information.

**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 C)

Dental Plan Election

Next Plan Year Choice:

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

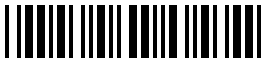
* **List Employee PCD:** ________________________________

(If spouse or child's PCD is different, indicate on section C)

Vision Plan Election

Next Plan Year Choice:

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



Employees Benefits Council Plan Year 2012

"""""""""""""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 C for coverage*

Invisible Bracelet

Next Plan Year Choice: **Yes** **No** **Total Number of Bracelets____________**

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)*

Next Plan Year Choice: ☐ **None** **$ ________ (per pay period) $ _________ (per plan year)**

Dependent Daycare Account

Next Plan Year Choice: ☐ **None** **$ ________ (per pay period) $ _________ (per plan year)**

Mass Trans Account

Next Plan Year Choice: ☐ **None** **$ ________ (per pay period) $ _________ (per plan year)**

Opt out of Health Benefits (requires 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 Council 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 C (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 201GPlan Year. Only list dependents you want to ADD or DROP from health, dental, vision, dependent life and Invisible Bracelet.
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	Social Security Number ________	___ Male ___ Female
Dental:	___ Add ___ Drop	Address ________	
Vision:	___ Add ___ Drop	________	
Dependent Life:	___ Add ___ Drop	Primary Care Physician (PCP) ________	
Bracelet:	___ Add ___ Drop	Primary Care Dentist (PCD) ________	

Name ________ Date of birth ________

Child:

Name ________ Date of birth ________

Health:	___ Add ___ Drop	Social Security Number ________	___ Male ___ Female
Dental:	___ Add ___ Drop	Address ________	
Vision:	___ Add ___ Drop	________	
Dependent Life:	___ Add ___ Drop	Primary Care Physician (PCP) ________	
Bracelet:	___ Add ___ Drop	Primary Care Dentist (PCD) ________	

Child:

Name ________ Date of birth ________

Health:	___ Add ___ Drop	Social Security Number ________	___ Male ___ Female
Dental:	___ Add ___ Drop	Address ________	
Vision:	___ Add ___ Drop	________	
Dependent Life:	___ Add ___ Drop	Primary Care Physician (PCP) ________	
Bracelet:	___ Add ___ Drop	Primary Care Dentist (PCD) ________	

Child:

Name ________ Date of birth ________

Health:	___ Add ___ Drop	Social Security Number ________	___ Male ___ Female
Dental:	___ Add ___ Drop	Address ________	
Vision:	___ Add ___ Drop	________	
Dependent Life:	___ Add ___ Drop	Primary Care Physician (PCP) ________	
Bracelet:	___ Add ___ Drop	Primary Care Dentist (PCD) ________	

Other:

Name ________ Date of birth ________

Health:	___ Add ___ Drop	Social Security Number ________	___ Male ___ Female
Dental:	___ Add ___ Drop	Address ________	
Vision:	___ Add ___ Drop	________	
Dependent Life:	___ Add ___ Drop	Primary Care Physician (PCP) ________	
Bracelet:	___ Add ___ Drop	Primary Care Dentist (PCD) ________	

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