OKLAHOMA
Employees Group Insurance Division

TRICARE SUPPLEMENT ENROLLMENT FORM

Employer information (to be completed by insurance coordinator)

Group ID	Division ID	Group name

Member information

Member name (First MI Last)	Member ID or SSN

Date of birth	☐ Male ☐ Female	☐ Married ☐ Single

Mailing address (☐ New) City State ZIP code

Phone	Alt phone	Email

Member health plan election

Enrollment status: ☐ New hire ☐ Midyear ☐ Option Period

Effective date of coverage		
Month	Day	Year
	01	

☐ **TRICARE Supplement Plan**

If you do not currently have TRICARE coverage as a current or former military member, EGID cannot enroll you in TRICARE coverage, and you are not eligible for the TRICARE Supplement Plan. In addition, if you are 65 or older, you are not eligible for the TRICARE Supplement Plan.

If you currently have TRICARE coverage, you can choose to enroll in the TRICARE Supplement Plan. Electing to purchase the TRICARE Supplement Plan means that TRICARE will be your primary health coverage and the supplement plan will be your secondary health coverage. The plan covers the cost shares and copays, including prescription drugs, a portion of the TRICARE deductible, and excess charges up to the legal limit. By your election, you submit to the eligibility rules of TRICARE and the TRICARE Supplement Plan. These rules may be different from the rules of eligibility created by the State of Oklahoma.

For EGID use only

Dependent information

Spouse name	SSN	Date of birth	☐ Male ☐ Female

Do you currently have coverage through EGID? (If yes, list name and SSN above.)
☐ Yes ☐ No

Health ☐ **Add**	Primary physician	☐ Current patient	☐ New patient

Child name	SSN	Date of birth	☐ Male ☐ Female

Health ☐ **Add**	Primary physician	☐ Current patient	☐ New patient

Child name	SSN	Date of birth	☐ Male ☐ Female

Health ☐ **Add**	Primary physician	☐ Current patient	☐ New patient

To list additional dependents, please obtain the Dependent Attachment Form from EGID.

Signatures

I certify that all selections made on this form are true and in compliance with the Plan Guidelines for Insurance Enrollment. Upon request, I agree to deliver documentation to EGID that authenticates this statement.

Members signature	Date

Spouse must sign if common-law or excluded from health, dental and/or vision coverage.

☐ **Common-law spouse certification:** I certify that this person listed above as my spouse and I have an actual and mutual agreement between ourselves to be married; this is a permanent relationship, and our relationship is exclusive, as proven by our cohabitation as spouses; and do hereby hold ourselves out publicly as married. I am aware that this relationship can be dissolved only by legal divorce.

☐ **Spouse exclusion certification (only required if children are covered and spouse is not):** I certify that I am aware I am being excluded from health, dental and/or vision coverage as indicated on this form.

Spouse signature	Date

I certify this enrollment is in compliance with the provisions of the employer's Section 125 Plan or, if no 125 Plan is offered, in compliance with new hire or allowed midyear coverage enrollment as defined by 26 U.S. Code § 125 of Title 26, the Internal Revenue Code (amended), and pertinent regulations.

Insurance coordinator signature	Date

This form must be returned to your insurance coordinator.