



**OKLAHOMA**  
Office of Management  
& Enterprise Services

# Planning For Your Insurance Needs

AS A FORMER EMPLOYEE



HEALTH | DENTAL | LIFE | VISION

2024



Employees Group  
Insurance Division

# This guide will lead you through the steps to continue your insurance after leaving active employment and explain which included forms you must complete.

## Your member status

When you leave active employment, you are given a member status based on your vesting right with a state funded retirement system or your years of employment service. There are four member status categories:

- **Vested** – You have worked long enough to keep insurance benefits and you contributed to a retirement system, but you are not ready to draw your retirement benefits.
- **Non-vested** – You have worked long enough to keep insurance benefits, but you did not contribute to a retirement system that participates with the Employees Group Insurance Division, or you withdrew your contributions from your retirement system.
- **Retiree** – You have worked long enough to leave active employment, keep insurance benefits and draw your retirement benefits.
- **Defer** – You have worked long enough to qualify as a vested, non-vested or retiree member, but you elect to transfer your health, dental or vision insurance to your spouse's current insurance through EGID.

If you leave active employment, lose coverage because of reduced hours or your employment is terminated for reasons other than gross misconduct, you can continue health, dental and vision coverage for up to 18 months under the Consolidated Omnibus Budget Reconciliation Act.

Coverage continued under COBRA is temporary. You are encouraged to retain your insurance benefits in a vested, non-vested, retiree or defer status if you meet the qualifications.

## Years of service you need to continue insurance at retirement

- **Teachers' Retirement System (TRS)** – Ten years minimum of creditable service.
- **Oklahoma Public Employees Retirement System (OPERS)** – Eight years minimum of creditable service.
- **Oklahoma Law Enforcement Retirement System (OLERS)** – Eight years minimum of creditable service.
- **Oklahoma Pathfinders Plan** – Five years minimum of creditable service.
- **Other or no retirement system** – Employment years may qualify as creditable service to continue insurance. Contact EGID Member Services for specific information.

## Plan premiums

Refer to the premium rate charts in this guide.

### Premium payment options

- **Retirement check deduction** – Your monthly premium for the previous month's coverage is automatically withheld from your retirement check. When selecting this option, the premium withheld is for the previous month's coverage.
- **Direct bill** – You are directly billed for your monthly premium due by the 20th of each month.
- **Automatic draft** – Your monthly premium is automatically drafted from your checking account on or around the 20th of each month. To elect this option, select the direct bill option on the Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage (Page A2) and provide EGID an Electronic Fund Transfer Authorization and a voided check. This form (Page D1-D2) is available on the EGID website or by contacting member services.

## Retirement system contribution to your monthly insurance premium

Your retirement system may contribute toward your health insurance premium.

- TRS contributes between \$100 to \$105 monthly.
- OPERS contributes \$105 monthly.
- OLCERS contributes \$105 monthly.
- Pathfinders does not contribute.

**The premiums listed in this guide do not reflect any retirement system contribution.**

## When you leave active employment

Keep all the coverage you think you will need in retirement. You can drop or reduce benefits later, but you cannot add health, dental or life insurance after you leave active employment.

Retirement is not a qualifying event that allows you to make plan changes unless you or your covered dependent is Medicare eligible. All covered dependents must enroll in the same plan. For example, if you are enrolled in an MAPD plan, your pre-Medicare dependents must enroll in the HMO option of that plan. If you move out of your health plan's service area, you are allowed to change health plans within 30 days of your move.

EGID Administrative Rule 260:50-3-13 (h) states that you must return to work for an EGID participating employer for three years to qualify to retain benefits not elected upon ceasing current employment.

If your employer offers these benefits through EGID, the following rules apply:

**Health and dental insurance** – You can add, keep, drop or defer coverage within 30 days of leaving active employment.

**Vision insurance** – You can add, keep, drop or defer coverage within 30 days of leaving active employment or during the annual Option Period.

Once you leave active employment, vision insurance is the only benefit that can be added during the annual Option Period.

**Life insurance** – You can keep, reduce or drop life coverage you have in place at the time you leave active employment. You must make the election within 30 days of leaving active employment. You cannot add or increase life insurance at retirement. Life insurance cannot be deferred and must be kept in your retirement account.

Life insurance must be kept in \$5,000 units. Refer to the premium charts included in this guide.

Life insurance continued at retirement does not include Accidental Death and Dismemberment benefits.

If you continue life insurance coverage when you leave active employment, it is very important to keep your beneficiary information current. If you are unsure of your beneficiary designations, please complete the Beneficiary Designation Form (Page E1). Instructions are on the back of the form.

HealthChoice must pay life benefits to the beneficiaries listed on the most recent beneficiary designation. If there is no signed beneficiary designation, benefits are paid to the estate.

## Coverage for your dependents

You can add, keep or drop health, dental and vision coverage for your spouse and other eligible dependents at retirement; however, dependent life insurance must be in effect before you leave active employment. Dependent coverage must be with the same carrier as the member.

You can exclude your spouse from health, dental and vision coverage and cover your other eligible dependents. Your spouse must sign the Spouse Exclusion Certification section of the Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage (Page A2).

If you add or keep coverage for your dependent children, including disabled dependents, you must cover all your eligible dependents up to age 26.

You can exclude dependents from coverage if they have other group coverage or are eligible for Indian Health Services or military health benefits. You can also exclude eligible dependents who do not reside with you, are married or are not financially dependent on you.

After retirement, you cannot add dependents to any coverage except vision, unless one of the following qualifying events occurs:

- Birth of a child.
- Your spouse or eligible dependents lose other group coverage.
- You marry.
- You adopt or gain legal guardianship of a child under age 26.

**You must add your spouse and any eligible dependents within 30 days of the qualifying event.**

## Dependent life insurance

You can keep dependent life insurance in effect at retirement but cannot add or increase it later. It must be kept in \$500 units and each covered dependent pays a separate, individual premium.

- **For your spouse** – The amount you keep for your spouse can be different from the amount you keep for your covered dependents.
- **For your dependents** – The amount you keep must be the same for each covered dependent.

## Surviving Dependents

In the event of your death, your surviving dependents may continue their insurance coverage. A surviving spouse can continue their insurance benefits, including Dependent Life, as long as the premiums are paid. The spouse will be moved to their own account and pay the primary member rate.

Surviving dependent children can also continue coverage, including Dependent Life, until age 26.

A letter will be sent by EGID to your surviving dependents advising them of their options. Dependents have 60 days to notify EGID that they wish to continue insurance coverage.

## If you decide to work past age 65

If you decide to work past age 65, you may contact Social Security to delay your enrollment in Medicare Part B. Your employer insurance will be primary payer while working. Since all insurance offered through EGID is creditable coverage, you will not be assessed a penalty once employer insurance ends.

## When you turn age 65 after you leave active employment

If you are close to age 65 and are not receiving Social Security benefits, you need to enroll in Medicare Part A and Part B.

To enroll, contact Social Security at least three months before you turn age 65. By enrolling early, you avoid any delay in the start of your Medicare coverage.

## COBRA

To comply with federal guidelines, a COBRA packet will be mailed to you when you leave employment. Do NOT complete this packet if you are electing to continue your insurance coverage as a Former Employee

# The Enrollment Process

## If you are not yet eligible for Medicare

### To continue your insurance

You must complete the Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage (Page A1) and return it to EGID.

### To defer (transfer) your coverage to your spouse's plan

If your spouse works and is currently enrolled in coverage through EGID, you can transfer your health, dental and vision coverage to your spouse's coverage as a dependent.

Life insurance cannot be deferred and must be kept in your retirement account.

To transfer your coverage to your spouse's plan:

- Mark Defer on the Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage (Page A1-A2) and return it to EGID.
- Your spouse must contact their employer to add you to their coverage as a dependent.
- Any retirement system contribution paid toward your health insurance premium will not be paid during the deferral period.

As long as your former employer group continues to participate with EGID, you can transfer your coverage back to your own EGID account at any time by completing the Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage.

## If you are eligible for Medicare

### About Medicare

Medicare is the federal health insurance program for people age 65 or older, people under age 65 with certain disabilities and those with end-stage renal disease or amyotrophic lateral sclerosis.

- **Medicare Part A** pays for hospitalization services.
- **Medicare Part B** pays for doctor and outpatient medical services. Call Social Security for information on your Part B premiums. Refer to Contact Information at the back of this guide.
- **Medicare Part D** pays for prescription drug coverage. All the plans offered through EGID provide Part D coverage. This means the plans all meet the benefit guidelines set by Medicare for creditable prescription drug coverage.

### Your enrollment in Medicare is handled in one of two ways:

- Automatic enrollment (depending on your individual circumstances).
- Application for enrollment. You should apply three months prior to turning 65 to avoid a possible delay in the start of your coverage.

Contact Social Security for more information.



### **To continue your insurance and enroll in a Medicare supplement or MAPD plan**

There are two forms you must complete to continue your health coverage:

- The Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage (Page A1).
- You must also complete the form associated with the plan you are enrolling in – the Application for Medicare Supplement With Prescription Drug Plan or the Application for Medicare Advantage Prescription Drug (MAPD) Plan.

Refer to Page 9 for the available Medicare plans.

### **To enroll in a Medicare supplement plan**

A Medicare supplement plan helps pay for some of the remaining out-of-pocket costs that original Medicare doesn't pay, such as copayments, coinsurance and deductibles. A Medicare supplement plan is in addition to original Medicare. To participate in a Medicare supplement plan, you must be entitled to benefits under Medicare Part A. EGID has three Medicare supplement plans. BCBSOK-BlueSecure requires Part B enrollment to participate in their plan. HealthChoice SilverScript High and Low Option Medicare Supplement plans do not require you to be enrolled in Part B, but pay benefits as if you are.

To enroll in a Medicare supplement plan, complete and return the Application for Medicare Supplement With Prescription Drug Plan (Page B1). You must provide your Medicare ID number to coordinate your benefits with Medicare.

### **To enroll in a Medicare Advantage Prescription Drug plan**

MAPD plans contract with Medicare to provide benefits for Medicare Part A and Part B covered services, as well as Part D prescription drug benefits.

You must be enrolled in Medicare Part A and Part B to be eligible for enrollment. When you enroll

in an MAPD plan, the plan replaces Medicare as your primary insurer.

To be eligible to enroll in an MAPD HMO, you must also live in the plan's approved ZIP code service area. You can receive services only within the plan's network.

To be eligible to enroll in an MAPD PPO, you may live anywhere in the United States. You can receive services anywhere in the U.S. as long as the provider is a Medicare eligible provider and accepts the plan's payment terms and conditions.

To enroll in an MAPD plan, you must complete and return the Application for Medicare Advantage Prescription Drug (MAPD) Plan (Page C1). Be sure to provide your Medicare ID number on your application.

## **Enrollment deadline**

### **If you are not eligible for Medicare**

EGID Administrative Rules allows 30 days from the day your active insurance ends to elect to begin or continue your insurance.

Failure to add, keep or defer coverage within 30 days of your active coverage ending cancels eligibility in the plans offered through EGID.

### **If you are eligible for Medicare**

It is important that your application is received at least 30 days **prior** to the day you leave active employment. This gives EGID enough time to process applications and resolve problems before coverage is effective. It also prevents delays in enrolling in a Part D prescription drug plan.

If your application is not received prior to your employment termination, you may be enrolled in a HealthChoice Medicare supplement plan that includes creditable prescription drug benefits, but not Part D prescription drug benefits, until the first of the following month. This is to prevent you from having a break in coverage. Be aware the premium for this temporary plan is higher.

### Plan ID cards

If you enroll in a Medicare plan through EGID, a new ID card will be issued. Do not destroy your current cards until you receive your new ones.

### If you move outside your plan's service area

#### If you are not eligible for Medicare

If you are enrolled in an HMO plan and move outside your plan's ZIP code service area, you must notify EGID in writing of your new address. To continue your health coverage, you will need to select a new plan that is in your service area.

#### If you are eligible for Medicare

If you are enrolled in an MAPD HMO plan and move outside your plan's ZIP code service area, you must contact EGID to disenroll. To change your coverage to a plan including Part D prescription drug benefits, you must complete an Application for Medicare Supplement With Prescription Drug Plan or an Application for Medicare Advantage Prescription Drug (MAPD) Plan.

### Address information

It is important to keep your mailing and email addresses current, or you risk delaying claims processing or missing important communications. Medicare requires that you report any change in your home address to your insurance plan.

Contact EGID Member Services for a Change of Address form, or submit a written request to:

EGID  
P.O. Box 11137  
Oklahoma City, OK 73136-9998

You can email your signed form to [EGIDMail@omes.ok.gov](mailto:EGIDMail@omes.ok.gov). Verbal requests for address changes are not accepted.

### Confirmation statement

When you enroll as a former employee or make changes to your coverage, EGID mails you a confirmation statement which lists the coverage you are enrolled in, the effective date of your coverage and the premium amounts.

Check it carefully. If incorrect, immediately contact EGID Member Services. Corrections must be submitted to EGID within 60 days of the election. Corrections reported after 60 days are effective the first of the month following notification. Refer to Contact Information at the back of this guide.

### Option Period

After you leave active employment, EGID mails your Option Period materials directly to you.

To make plan changes, complete your Option Period form and return it directly to EGID. Keep a copy of your form for your records. EGID will mail you a confirmation statement.

If you have no plan changes, do not return your form. You will not receive a confirmation statement.

# Monthly Premiums for Former Employees and Surviving Dependents Plan Year Jan. 1-Dec. 31, 2024



**OKLAHOMA**  
Office of Management  
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HEALTH PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Blue Cross Blue Shield of Oklahoma – BlueLincs HMO	\$ 600.78	\$ 825.98	\$ 556.90	\$ 1299.08
CommunityCare HMO	\$ 650.06	\$ 762.16	\$ 326.98	\$ 554.88
GlobalHealth HMO	\$ 979.42	\$ 1445.72	\$ 559.30	\$ 913.38
HealthChoice High and High Alternative	\$ 679.62	\$ 796.80	\$ 341.86	\$ 580.10
HealthChoice Basic and Basic Alternative	\$ 543.08	\$ 637.32	\$ 280.06	\$ 473.72
HealthChoice High Deductible Health Plan (HDHP)	\$ 473.68	\$ 556.24	\$ 244.66	\$ 413.06

DENTAL PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
BCBSOK – BlueCare Dental High Plan	\$ 35.08	\$ 35.08	\$ 28.44	\$ 72.52
BCBSOK – BlueCare Dental Low Plan	\$ 23.84	\$ 23.84	\$ 20.60	\$ 50.40
Cigna Prepaid High (K1I09)	\$ 13.56	\$ 10.98	\$ 8.40	\$ 14.44
Cigna Prepaid Low (OKIV9)	\$ 10.48	\$ 6.80	\$ 4.62	\$ 10.42
Delta Dental PPO	\$ 39.70	\$ 39.70	\$ 34.54	\$ 87.30
Delta Dental PPO – Choice	\$ 17.88	\$ 40.50	\$ 40.80	\$ 99.02
HealthChoice Dental	\$ 48.58	\$ 48.58	\$ 39.28	\$ 100.74
MetLife High Classic MAC	\$ 50.90	\$ 50.90	\$ 43.62	\$ 107.98
MetLife Low Classic MAC	\$ 28.90	\$ 28.90	\$ 24.78	\$ 60.94
Sun Life Preferred Active PPO	\$ 34.98	\$ 34.80	\$ 26.12	\$ 70.14

VISION PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Primary Vision Care Services (PVCS)	\$ 10.40	\$ 9.28	\$ 9.20	\$ 11.50
Superior Vision	\$ 7.40	\$ 7.34	\$ 6.96	\$ 14.30
Vision Care Direct	\$ 15.48	\$ 10.96	\$ 10.96	\$ 24.48
VSP (Vision Service Plan)	\$ 8.62	\$ 5.66	\$ 5.58	\$ 12.22

## LIFE PLAN FOR PRE-MEDICARE RETIREES/VESTED MEMBERS

From \$5,000 to \$40,000 \$3.12 Per \$1,000 unit

### AGE-RATED SUPPLEMENTAL LIFE – Cost per \$1,000 unit for \$41,000 and up

<30 – \$0.06	30-34 – \$0.06	35-39 – \$0.06	40-44 – \$0.08
45-49 – \$0.14	50-54 – \$0.26	55-59 – \$0.40	60-64 – \$0.46
65-69 – \$0.74	70-74 – \$1.28	75+ – \$1.96	

**DEPENDENT LIFE** \$1.56 per \$500 unit, per dependent

## MONTHLY LIFE INSURANCE PREMIUMS FOR SURVIVING DEPENDENTS

Surviving Dependents of Current Employees	Low Option \$2.60	Standard Option \$4.32	Premier Option \$11.26
Spouse	\$ 6,000 of coverage	\$ 10,000 of coverage	\$ 20,000 of coverage
Child (live birth to age 26)	\$ 3,000 of coverage	\$ 5,000 of coverage	\$ 10,000 of coverage
Surviving Dependents of Former Employees	\$1.56 per \$500 unit, per dependent		

These rates do not reflect any retirement system contribution.



# Monthly Premiums for Medicare Eligible Members Plan Year Jan. 1-Dec. 31, 2024



**OKLAHOMA**  
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& Enterprise Services

## MEDICARE SUPPLEMENT PLANS

BCBSOK – BlueSecure <sup>SM</sup>	\$ 466.02 per covered person
HealthChoice SilverScript High Option Medicare Supplement	\$ 437.00 per covered person
HealthChoice SilverScript Low Option Medicare Supplement	\$ 356.06 per covered person

## MEDICARE ADVANTAGE PRESCRIPTION DRUG (MAPD) PLANS

BCBSOK – MAPD	\$ 238.40 per covered person
CommunityCare Senior Health Plan	\$ 215.64 per covered person
Generations by GlobalHealth	\$ 199.00 per covered person
Humana MAPD PPO	\$ 192.92 per covered person

DENTAL PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
BCBSOK – BlueCare Dental High Plan	\$ 35.08	\$ 35.08	\$ 28.44	\$ 72.52
BCBSOK – BlueCare Dental Low Plan	\$ 23.84	\$ 23.84	\$ 20.60	\$ 50.40
Cigna Prepaid High (K1I09)	\$ 13.56	\$ 10.98	\$ 8.40	\$ 14.44
Cigna Prepaid Low (OKIV9)	\$ 10.48	\$ 6.80	\$ 4.62	\$ 10.42
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VSP (Vision Service Plan)	\$ 8.62	\$ 5.66	\$ 5.58	\$ 12.22

## LIFE PLAN

From \$5,000 to \$40,000 \$3.12 Per \$1,000 unit

### AGE-RATED SUPPLEMENTAL LIFE – Cost per \$1,000 unit for \$41,000 and up

<30 – \$0.06	30-34 – \$0.06	35-39 – \$0.06	40-44 – \$0.08
45-49 – \$0.14	50-54 – \$0.26	55-59 – \$0.40	60-64 – \$0.46
65-69 – \$0.74	70-74 – \$1.28	75+ – \$1.96	

## DEPENDENT LIFE

\$1.56 per \$500 unit, per dependent

These rates do not reflect any contribution from your retirement system.

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# FORMS





**Employees Group Insurance Division**  
**APPLICATION FOR RETIREE/VESTED**  
**NON-VESTED/DEFER INSURANCE COVERAGE**

**RETIREMENT SYSTEM** ☐ **OPERS** ☐ **TRS** ☐ **OLERS** ☐ **PATHFINDER** ☐ **OTHER**

My member status will be ☐ Retiree ☐ Vested ☐ Non-vested ☐ Defer (See instructions on page 3.)

**For defer only:** Spouse's Social Security number or member ID number \_\_\_\_\_

☐ Cancel my deferment and reinstate my retiree/vested/non-vested insurance coverage.

**MEMBER INFORMATION**

SSN or member ID \_\_\_\_\_ Member's birth date \_\_\_\_\_ Gender ☐ Male ☐ Female

Member's name \_\_\_\_\_ Employer \_\_\_\_\_  
First M.I. Last

Mailing address \_\_\_\_\_  
Street City State ZIP code

Phone \_\_\_\_\_ Alt. phone \_\_\_\_\_ Email \_\_\_\_\_

Last date of employee insurance coverage	Mo.	Day	Yr.

Vested/ non-vested insurance effective date	Mo.	Day	Yr.
		0 1	

Retirement Insurance effective date	Mo.	Day	Yr.
		0 1	

**MEMBER HEALTH PLAN** ☐ **Add/keep** ☐ **Drop** ☐ **Defer**

Health plan name \_\_\_\_\_ ☐ Check if Medicare-eligible\*

Primary physician (HMO only) \_\_\_\_\_ ☐ Current patient ☐ New patient

\* If you and/or your dependents are eligible for Medicare, an additional application must be completed. Please contact EGID Member Services to request an application.

**MEMBER DENTAL PLAN** ☐ **Add/keep** ☐ **Drop** ☐ **Defer**

Dental plan name \_\_\_\_\_

Primary dentist (Prepaid only) \_\_\_\_\_  
☐ Current patient ☐ New patient

**MEMBER VISION PLAN** ☐ **Add/keep** ☐ **Drop** ☐ **Defer**

Vision plan name \_\_\_\_\_

For EGID Use Only

**MEMBER LIFE INSURANCE**

You can keep a minimum of \$5,000 up to the total amount of your current life insurance. You cannot enroll in more life insurance than you currently have. You must keep life insurance on yourself to be able to keep life insurance on your dependents. You cannot increase life insurance after this election. Life insurance **cannot be deferred** and must be carried as a primary retiree/vested member.

☐ I elect to keep \$ \_\_\_\_\_ (\$5,000 to \$40,000 in \$5,000 units) of member life insurance at a flat rate per \$1,000 of coverage.

☐ I elect to keep \$ \_\_\_\_\_ (amount above \$40,000 in \$5,000 units) of additional life insurance.

## DEPENDENT INFORMATION

NOTE: If you and/or your dependents are eligible for Medicare, an additional application must be completed. Please contact EGID Member Services to request an application. You cannot add dependent life if you do not already have it. The dependent life amount must be the same for each child, though the amount for your spouse can be different.

### SPOUSE

Name \_\_\_\_\_ ☐ Check if Medicare-eligible.  
**Add/keep Drop** SSN \_\_\_\_\_ Date of birth \_\_\_\_\_ ☐ Male ☐ Female  
Health ☐ ☐ Primary physician (HMO only) \_\_\_\_\_ ☐ New patient ☐ Current patient  
Dental ☐ ☐ Primary dentist (Prepaid only) \_\_\_\_\_ ☐ New patient ☐ Current patient  
Vision ☐ ☐  
Dep. life ☐ ☐ I elect to keep \$ \_\_\_\_\_ (in \$500 units) of dependent life insurance.

Does your spouse currently have coverage through OMES EGID? ☐ Yes ☐ No  
(If yes, list name and Social Security number above.)

### CHILD

Name \_\_\_\_\_ ☐ Check if Medicare-eligible.  
**Add/keep Drop** SSN \_\_\_\_\_ Date of birth \_\_\_\_\_ ☐ Male ☐ Female  
Health ☐ ☐ Primary physician (HMO only) \_\_\_\_\_ ☐ New patient ☐ Current patient  
Dental ☐ ☐ Primary dentist (Prepaid only) \_\_\_\_\_ ☐ New patient ☐ Current patient  
Vision ☐ ☐  
Dep. life ☐ ☐ I elect to keep \$ \_\_\_\_\_ (in \$500 units) of dependent life insurance.

## CERTIFICATION SIGNATURES

- ☐ I authorize EGID to deduct the amount of my premiums from my retirement check according to Administrative Rule 260:50-3-5. (You must verify with your retirement system that your retirement check will cover your premiums.)
- ☐ I request EGID direct bill me for my monthly premiums at the mailing address on this form.

Spouse must sign if **being excluded from health, dental and/or vision** or if they are a **common-law spouse**.

- ☐ Spouse exclusion certification: I certify that I am aware I am being **excluded from health, dental and/or vision coverage** as indicated on this form. I am also aware that I cannot be added to coverage at a later date except within 30 days of the loss of other coverage. (Required only if children are covered and spouse is not.)
- ☐ Common-law spouse certification: I certify the person listed as my spouse and I have an actual and mutual agreement between ourselves to be married; that this is a permanent relationship; that our relationship is exclusive, as proven by our cohabitation as spouses; and that we do hereby hold ourselves out publicly as married. I am aware this relationship **can be dissolved only by legal divorce**.

Spouse signature \_\_\_\_\_ Date \_\_\_\_\_

**I understand that no coverage, except vision, can be added at a later date.**

Member signature \_\_\_\_\_ Date \_\_\_\_\_

## **Retirement information can be found at [oklahoma.gov/omes](http://oklahoma.gov/omes).**

You can carry health, dental, vision and life insurance on yourself and your dependents.

The health, dental and life coverage you take into retiree/vested/non-vested status is the only coverage you can have with EGID through your retirement years. If you do not keep coverage now, you cannot add it later. Plan changes can be made during the annual Option Period.

If you are insuring one dependent, you must insure all eligible dependents (for any given coverage) unless they are covered by other insurance or Indian or military benefits. Children who have Indian or military benefits or other insurance may be required to show proof of coverage.

Following your retirement, dependents can be added only within 30 days of one of the following events: birth, adoption or guardianship, marriage or loss of other group insurance.

**DEFER INSTRUCTIONS:** If your spouse has separate coverage through EGID at the time you terminate employment, you can transfer your individual health, dental and/or vision coverage to dependent coverage under your spouse's coverage. Your spouse must contact their employer to add you as a dependent. You must elect to transfer coverage within 30 days of your termination of employment. Any 30-day break in coverage voids your eligibility to keep coverage in the future. Life insurance cannot be deferred and must be carried as a primary retiree/vested/non-vested member. When you are ready to return to retiree/vested/non-vested status, you must again complete this form and mark the box on Page 1 of your form to cancel your deferment.

### **THINGS TO CONSIDER AS A RETIREE WHEN YOU BECOME MEDICARE-ELIGIBLE**

**IMPORTANT:** If you are under age 65 and eligible for Medicare, you must notify EGID and provide your Medicare number as it appears on your Medicare card. Medicare supplement coverage is effective the date you become eligible for Medicare or the first day of the month following notification of your Medicare eligibility, whichever is later.

When you turn age 65, you have the option to enroll in either a Medicare supplement with prescription drug plan or a Medicare Advantage prescription drug plan.

**BCBSOK-BlueSecure and all MAPD plans offered through EGID require you to have both Medicare Part A and Medicare Part B.**

If you are eligible and do not enroll in Medicare Part B, there are two Medicare supplement plans available to you: HealthChoice SilverScript High Option Medicare Supplement Plan and HealthChoice SilverScript Low Option Medicare Supplement Plan. All medical benefits under these plans are paid as if you are enrolled in both Medicare Part A and Part B. If you are not enrolled in Medicare Part B, your plan will estimate Medicare's benefits and provide supplemental coverage as if Medicare is the primary carrier. This means HealthChoice pays secondary and you are responsible for the primary share of the claim.

For information concerning HMO, MAPD, Medicare supplement, dental or vision plans, contact their customer service numbers.

For information regarding enrollment, or to obtain an application for a Medicare supplement plan or MAPD plan, call 405-717-8780 or toll-free 800-752-9475 or TTY 711 or contact:

OMES Employees Group Insurance Division  
P.O. Box 11137  
Oklahoma City, OK 73136-9998





**Who can use this form?** People with Medicare who want to join a Medicare prescription drug plan.

**To join a plan, you must:**

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area.

**Important:**

To join a HealthChoice SilverScript Medicare supplement with prescription drug plan, you must have either, or both:

- Medicare Part A (hospital insurance).
- Medicare Part B (medical insurance).

To join the BCBSOK Medicare supplement with prescription drug plan, you must have both:

- Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).

**When do I use this form?**

You can join a plan:

- Between Oct. 15-Dec. 7 each year (for coverage starting Jan. 1).
- Within three months of first getting Medicare.
- In certain situations where you're allowed to join or switch plans. Visit [Medicare.gov](https://www.Medicare.gov) to learn more about when you can sign up for a plan.

**What do I need to complete this form?**

- Your Medicare Number (the number on your red, white and blue Medicare card).
- Your permanent address and phone number.

**Reminder:**

- If you want to join a plan during fall open enrollment (Oct. 15-Dec. 7), the plan must have your completed form by Dec. 7.

**What happens next?**

Send your completed and signed form to:

OMES EGID

P.O. Box 11137

Oklahoma City, OK 73136-9998

Once they process your request to join, they'll contact you.

**How do I get help with this form?**

Call EGID Member Services at 405-717-8780 or toll-free 800-752-9475 Monday-Friday, 8 a.m. to 4:30 p.m. Central time to see if you are eligible to enroll. TTY users call 711. Or, call Medicare at 800-MEDICARE (800-633-4227). TTY users call 877-486-2048. **En español:** Llame a EGID al 800-752-9475/TTY 711 o a Medicare gratis al 800-633-4227 y oprima el 2 para asistencia en español y un representante estara disponible para asistirle.

**Individuals experiencing homelessness**

If you want to join a plan but have no permanent residence, a post office box, an address of a shelter or clinic, or the address where you receive mail (e.g., Social Security checks) may be considered your permanent residence address.



### Member information

Member name (First MI Last)		Member ID
Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Member SSN
Permanent address (P.O. Box not allowed)	City	State ZIP code
Mailing address (if different from above)	City	State ZIP code
Phone	Alternate phone	Email

### Dependent information (only if enrolling in Medicare)

Dependent name (First MI Last)		
Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Dependent SSN

### Your Medicare information (required to process your application)

Name on Medicare card:

Medicare number: \_ \_ \_ \_ - \_ \_ \_ - \_ \_ \_ \_

Part A effective date:

Part B effective date:

To participate in the BCBSOK Medicare supplement plan, you must be enrolled in both Medicare Part A (hospital) and Part B (medical) and continue to pay your monthly Part B premium. To participate in the HealthChoice Medicare supplement plans, you must be entitled to benefits under Medicare Part A. You are not required to be in enrolled in Part B, but the plan pays benefits as if you are. To maximize your benefits, you need to be enrolled in Medicare Part B.

### Answer these important questions

1. In which Medicare supplement with Medicare Part D prescription drug plan do you want to enroll?

HealthChoice SilverScript Medicare Supplement Plan

☐ High ☐ Low

☐ BCBSOK – BlueSecure

2. Some individuals may have other drug coverage through private insurance, TRICARE, federal employee health benefits, VA benefits or state pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to your coverage through OMES Employees Group Insurance Division?

☐ Yes

☐ No

Name of other coverage

ID#

Group#

3. Typically, you can enroll in a Medicare prescription drug plan only during the annual enrollment period from Oct. 15 through Dec. 7. Additionally, there are exceptions that may allow you to enroll in a Medicare prescription drug plan outside of the Annual Enrollment Period. (Refer to statements on Page 2.)

☐ I am enrolling during an Annual Enrollment Period (Option Period).

**Read the following statements and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an enrollment period. If we later determine that this information is incorrect, you may be disenrolled.**

- ☐ I am new to Medicare.
- 
- ☐ I recently moved outside of the service area of my current plan. I moved on (insert date):
- 
- ☐ I recently was released from incarceration. I was released on (insert date):
- 
- ☐ I recently returned to the U.S. after living permanently outside of the U.S. I returned to the U.S. on (insert date):
- 
- ☐ I recently obtained lawful presence status in the U.S. I got this status on (insert date):
- 
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance or lost Medicaid) on (insert date):
- 
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in level of Extra Help or lost Extra Help) on (insert date):
- 
- ☐ I have both Medicare and Medicaid or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- 
- ☐ I live in or recently moved out of a long-term care facility (for example, a nursing home or other long-term care facility). I moved/will move into/out of the facility on (insert date):
- 
- ☐ I recently left a PACE program on (insert date):
- 
- ☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on (insert date):
- 
- ☐ I am leaving employer or union coverage on (insert date):
- 
- ☐ I belong to a pharmacy assistance program provided by my state.
- 
- ☐ I was enrolled in a plan by Medicare (or my state), and I want to choose a different plan. My enrollment in that plan started on (insert date):
- 
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
- 
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- 
- ☐ None of these statements apply to me. Call EGID at 405-717-8780 or toll-free 800-752-9475 Monday-Friday, 8 a.m. to 4:30 p.m. Central time to see if you are eligible to enroll. TTY users call 711.

**Answering these questions is your choice. You cannot be denied coverage if you don't answer.**

**4. Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.**

- |   |  |
|---|--|
| <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin   | <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a |
| <input type="checkbox"/> Yes, Puerto Rican                                  | <input type="checkbox"/> Yes, Cuban                                |
| <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin |  |
| <input type="checkbox"/> I choose not to answer.                            |  |

**5. What's your race?**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Asian Indian           | <input type="checkbox"/> Black or African American |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Filipino               | <input type="checkbox"/> Guamanian or Chamorro     |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> Korean                 | <input type="checkbox"/> Native Hawaiian           |
| <input type="checkbox"/> Other Asian                      | <input type="checkbox"/> Other Pacific Islander | <input type="checkbox"/> Samoan                    |
| <input type="checkbox"/> Vietnamese                       | <input type="checkbox"/> White                  |  |
| <input type="checkbox"/> I choose not to answer.          |   |  |

## Signatures Important: Read and sign below

- I must keep Part A or Part B to stay in the plans offered by EGID.
- By joining this Medicare supplement with prescription drug plan, I acknowledge that the Medicare supplement with prescription drug plans offered by EGID will release my information to Medicare, who may use it to track beneficiary enrollment, for payment and other purposes applicable to federal statutes that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  - 1) This person is authorized under state law to complete this enrollment.
  - 2) Documentation of this authority is available upon request by Medicare.

Member signature	Date
Dependent signature (only if dependent is enrolling in Medicare)	Date
<b>If you are the authorized representative, you must sign above and provide this information:</b>	
Name	Phone
Address	
Relationship to enrollee	

## Mail or fax the form to Attn: Member Accounts

**Mail:** OMES EGID  
P.O. Box 11137  
Oklahoma City, OK 73136-9998

**Fax:** 405-717-8939

## 2024 monthly premium information does not reflect any retirement system contribution

### MEDICARE SUPPLEMENT WITH PRESCRIPTION DRUG PLANS

BCBSOK – BlueSecure	\$466.02 per covered person
HealthChoice SilverScript High Option Medicare Supplement	\$437.00 per covered person
HealthChoice SilverScript Low Option Medicare Supplement	\$356.06 per covered person

## Privacy Act Statement

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1860D-1 of the Social Security Act and 42 CFR §§ 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

**If you have questions, call EGID Member Services at  
405-717-8780 or toll-free 800-752-9475. TTY users call 711.**

**Who can use this form?** People with Medicare who want to join a Medicare Advantage prescription drug plan.

**To join a plan, you must:**

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area.

**Important:**

To join a Medicare prescription drug plan, you must also have both:

- Medicare Part A (hospital insurance).
- Medicare Part B (medical insurance).

**When do I use this form?**

You can join a plan:

- Between Oct. 15-Dec. 7 each year (for coverage starting Jan. 1).
- Within three months of first getting Medicare.
- In certain situations where you're allowed to join or switch plans. Visit [Medicare.gov](https://www.medicare.gov) to learn more about when you can sign up for a plan.

**What do I need to complete this form?**

- Your Medicare Number (the number on your red, white and blue Medicare card).
- Your permanent address and phone number.

**Reminder:**

- If you want to join a plan during fall open enrollment (Oct. 15-Dec. 7), the plan must have your completed form by Dec. 7.

**What happens next?**

Send your completed and signed form to:

OMES EGID

P.O. Box 11137

Oklahoma City, OK 73136-9998

Once they process your request to join, they'll contact you.

**How do I get help with this form?**

Call EGID Member Services at 405-717-8780 or toll-free 800-752-9475 Monday-Friday, 8 a.m. to 4:30 p.m. Central time to see if you are eligible to enroll. TTY users call 711. Or, call Medicare at 800-MEDICARE (800-633-4227). TTY users can call 877-486-2048. **En español:** Llame a EGID al 800-752-9475/TTY 711 o a Medicare gratis al 800-633-4227 y oprima el 2 para asistencia en español y un representante estara disponible para asistirle.

**Individuals experiencing homelessness**

If you want to join a plan but have no permanent residence, a post office box, an address of a shelter or clinic, or the address where you receive mail (e.g., Social Security checks) may be considered your permanent residence address.



### Member information

Member name (First MI Last)		Member ID
Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Member SSN
Permanent address (P.O. Box not allowed) City State		ZIP code
Mailing address (if different from above) City State		ZIP code
Phone	Alternate phone	Email

### Dependent information (only if enrolling in Medicare)

Dependent name (First MI Last)		
Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Dependent SSN

### Your Medicare information (required to process your application)

Name on Medicare card:

Medicare number: \_ \_ \_ \_ - \_ \_ \_ - \_ \_ \_ \_

Part A effective date:

Part B effective date:

You must have Medicare Part A and Part B to join an MAPD plan.

### Answer these important questions

1. In which MAPD plan do you want to enroll?

☐ BCBSOK – MAPD

☐ CommunityCare Senior Health Plan

☐ Generations by GlobalHealth

☐ Humana MAPD PPO

2. Some individuals may have other drug coverage through private insurance, TRICARE, federal employee health benefits, VA benefits or state pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to your coverage through OMES Employees Group Insurance Division?

☐ Yes

☐ No

Name of other coverage

ID#

Group#

3. Typically, you can enroll in a Medicare prescription drug plan only during the annual enrollment period from Oct. 15 through Dec. 7 each year. Additionally, there are exceptions that may allow you to enroll in a Medicare prescription drug plan outside of the Annual Enrollment Period. (Refer to statements on Page 2.)

☐ I am enrolling during an Annual Enrollment Period (Option Period).



**Read the following statements and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an enrollment period. If we later determine that this information is incorrect, you may be disenrolled.**

- ☐ I am new to Medicare.
- 
- ☐ I recently moved outside of the service area of my current plan. I moved on (insert date):
- 
- ☐ I recently was released from incarceration. I was released on (insert date):
- 
- ☐ I recently returned to the U.S. after living permanently outside of the U.S. I returned to the U.S. on (insert date):
- 
- ☐ I recently obtained lawful presence status in the U.S. I got this status on (insert date):
- 
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance or lost Medicaid) on (insert date):
- 
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in level of Extra Help or lost Extra Help) on (insert date):
- 
- ☐ I have both Medicare and Medicaid or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- 
- ☐ I live in or recently moved out of a long-term care facility (for example, a nursing home or other long-term care facility). I moved/will move into/out of the facility on (insert date):
- 
- ☐ I recently left a PACE program on (insert date):
- 
- ☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on (insert date):
- 
- ☐ I am leaving employer or union coverage on (insert date):
- 
- ☐ I belong to a pharmacy assistance program provided by my state.
- 
- ☐ I was enrolled in a plan by Medicare (or my state), and I want to choose a different plan. My enrollment in that plan started on (insert date):
- 
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
- 
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- 
- ☐ None of these statements apply to me. Call EGID at 405-717-8780 or toll-free 800-752-9475 Monday-Friday, 8 a.m. to 4:30 p.m. Central time to see if you are eligible to enroll. TTY users call 711.

**Answering these questions is your choice. You cannot be denied coverage if you don't answer.**

**4. Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.**

- |   |  |
|---|--|
| <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin   | <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a |
| <input type="checkbox"/> Yes, Puerto Rican                                  | <input type="checkbox"/> Yes, Cuban                                |
| <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin |  |
| <input type="checkbox"/> I choose not to answer.                            |  |

**5. What's your race?**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Asian Indian           | <input type="checkbox"/> Black or African American |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Filipino               | <input type="checkbox"/> Guamanian or Chamorro     |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> Korean                 | <input type="checkbox"/> Native Hawaiian           |
| <input type="checkbox"/> Other Asian                      | <input type="checkbox"/> Other Pacific Islander | <input type="checkbox"/> Samoan                    |
| <input type="checkbox"/> Vietnamese                       | <input type="checkbox"/> White                  |  |
| <input type="checkbox"/> I choose not to answer.          |   |  |

**6. Would you prefer that the MAPD plan send you information in a language other than English or in another format?**

- ☐ Yes    ☐ No

## Primary care physician selection

As an MAPD plan member with CommunityCare Senior Health Plan or Generations by GlobalHealth, you must choose a PCP who will coordinate your health care. You can obtain a list of the plan's network physicians by contacting the plan or visiting their website.

Physician name (First Last)	Are you a current patient of this physician? <input type="checkbox"/> Yes <input type="checkbox"/> No
-----------------------------	--

## Signatures Important: Read and sign below

- I must keep both Part A and Part B to stay in the plans offered by EGID.
- By joining this Medicare Advantage plan, I acknowledge the Medicare Advantage prescription drug plans offered by EGID will release my information to Medicare, who may use it to track beneficiary enrollment, for payment and other purposes applicable to federal statutes that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my MAPD coverage through EGID begins, I must get all of my medical and prescription drug benefits from that plan. Benefits and services provided by my plan and contained in my evidence of coverage document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor my plan will pay for benefit or services that are not covered.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  - 1) This person is authorized under state law to complete this enrollment.
  - 2) Documentation of this authority is available upon request by Medicare.

Member signature	Date
Dependent signature (only if dependent is enrolling in Medicare)	Date

## If you are the authorized representative, you must sign above and provide this information

Name	Phone
Address	
Relationship to enrollee	

## Mail or fax the form to Attn: Member Accounts

**Mail:** OMES EGID  
P.O. Box 11137  
Oklahoma City, OK 73136-9998

**Fax:** 405-717-8939

## 2024 monthly premium information does not reflect any retirement system contribution

### MEDICARE ADVANTAGE PRESCRIPTION DRUG (MAPD) PLANS

BCBSOK – MAPD	\$238.40 per covered person
CommunityCare Senior Health Plan	\$215.64 per covered person
Generations by GlobalHealth	\$199.00 per covered person
Humana MAPD PPO	\$192.92 per covered person

## Privacy Act Statement

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1860D-1 of the Social Security Act and 42 CFR §§ 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

**If you have questions, call EGID Member Services at  
405-717-8780 or toll-free 800-752-9475. TTY users call 711.**



Re: Automatic Bank Withdrawal for Insurance Premium

The Office of Management and Enterprise Services Employees Group Insurance Division is pleased to offer you a convenient way to pay your monthly insurance premiums. Through a program established by the Office of the State Treasurer, upon your authorization, EGID will automatically draft your bank account for your monthly insurance premiums.

If you wish to participate, your bank account will be debited on the 20th of each month, and you will not need to mail a check for your insurance premium. There is no charge for this service.

Once you are enrolled in this process, you will no longer receive a monthly bill from us. EGID will notify you of any change in the monthly debit amount. This process will continue as long as you have insurance through EGID, until you notify us in writing that you no longer wish to participate, or until a debit does not clear your bank.

We encourage you to take advantage of direct debiting by completing the enclosed authorization form. A confirmation will be sent to you showing the amount that will be debited every month along with the month in which this process will begin.

**The authorization form must be received in our office by the 10th of the month to be effective for the current month's premium. Forms received after the 10th will be effective the following month. Premiums are required to be paid in full prior to enrolling in direct debiting.**

If you have any questions, call EGID Member Services at 405-717-8780 or 800-752-9475. TTY users call 711.



Member name \_\_\_\_\_

SSN or member ID \_\_\_\_\_

Member's financial institution \_\_\_\_\_

I hereby authorize the Office of the State Treasurer to initiate debit entries for the checking account at the financial institution indicated above for amounts due to the Office of Management and Enterprise Services Employees Group Insurance Division. This authority is to remain in full force and effect until one of the following occurs:

- EGID has received notification from the insured of his or her desire to stop participating in automatic bank withdrawals. The notice must be made at least one week before the debit date.
- The Office of the State Treasurer is unable to debit the account for any month because of a closed account, insufficient funds or any other reason.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Attach a voided check here. Deposit slips **will not be accepted**.

**ATTACH CHECK HERE**

**This authorization form must be received in our office by the 10th of the month to be effective for the current month's premium. Forms received after the 10th will be effective the following month. Premiums are required to be paid in full prior to enrolling in direct debiting.**

Please mail this completed form to:

EGID MEMBER ACCOUNTS  
P.O. BOX 11137  
OKLAHOMA CITY, OK 73136-9998



## Employees Group Insurance Division Beneficiary Designation Form

Please read the instructions carefully and complete this form in ink.

SSN or Member ID: \_\_\_\_\_ Member Name: \_\_\_\_\_  
First MI Last

Address: \_\_\_\_\_  
☐ New Address Street City State ZIP

Phone: (\_\_\_\_) \_\_\_\_\_ Alt Phone: (\_\_\_\_) \_\_\_\_\_

**Important\*:** Please ensure the "Share Percentage" section in both Primary Beneficiary(ies) and Contingent Beneficiary(ies) add up to 100 percent. Payment will be made in equal shares to all surviving beneficiaries unless otherwise indicated.

### PRIMARY BENEFICIARY(IES)

Primary Beneficiary's Name and Address	SSN	Phone #	Relationship	Date of Birth	Share Percentage
					100%

### CONTINGENT BENEFICIARY(IES)

Proceeds are paid to the contingent beneficiary(ies) identified below only if there is no surviving primary beneficiary(ies).

Contingent Beneficiary's Name and Address	SSN	Phone #	Relationship	Date of Birth	Share Percentage
					100%

I have named the above beneficiary(ies) to receive my life insurance benefits from HealthChoice. I understand this form replaces and cancels all prior beneficiary designations and will become effective only when it is received by EGID.

\_\_\_\_\_  
Member Signature - original signature required

\_\_\_\_\_  
Date

Mail this form to OMES EGID at P.O. Box 11137, Oklahoma City, OK 73136-9998

## Instructions for Completing the Beneficiary Designation Form

This beneficiary form applies to the HealthChoice Life Insurance Plan offered through the Office of Management and Enterprise Services Employees Group Insurance Division. If you are retired, it does not affect the beneficiaries for any death benefit you may have through your retirement system.

The beneficiary designations you make on this form replace and cancel all prior life insurance beneficiary designations with EGID. Your designations do not become effective until this form is **signed** and **received** by EGID. Do not alter this form or attach additional pages.

It is very important that you provide the **full legal name, address, relationship, date of birth and Social Security number of each beneficiary you designate**. This information is essential in ensuring that your named beneficiaries can be located and receive your intended benefit amount. The Beneficiary Designation Form has three parts: Member Information, Primary and Contingent Beneficiary Designation and Signature. **Please print clearly in ink.**

**Employer Name** – Provide the name of your employer. This information is not required of a former employee/retiree.

**Member Information** – Provide your name, SSN or Member ID and address.

**Primary Beneficiary Designation** – You can designate one or more primary beneficiaries. All primary beneficiaries share equally, unless you note otherwise. In the event that multiple primary beneficiaries are named and a primary beneficiary dies before or simultaneously with you, the remaining primary beneficiary(ies) will be entitled to equal share of the deceased beneficiary's designated benefit amount.

**Contingent Beneficiary Designation** – You can designate one or more contingent beneficiaries. Contingent beneficiaries receive benefits only in the event all primary beneficiaries die before or simultaneously with you. All contingent beneficiaries share equally, unless you note otherwise on your form. In the event that multiple contingent beneficiaries are named and a contingent beneficiary dies before or simultaneously with you, the remaining contingent beneficiary(ies) will be entitled to equal share of the deceased beneficiary's designated benefit amount.

**Signature** – You must sign and date your form.

### Special Beneficiary Designations

Sometimes members wish to make a special designation for trusts, minors or institutions. If you wish to make a special designation, please read the following information carefully.

**Designating a trust as beneficiary** – To designate a trust as beneficiary, provide the actual name of the trust and the date the trust was created in the space provided.

**Designating a minor as beneficiary** – A minor can be named your beneficiary; however, it is often difficult and costly for a minor to receive payment, especially if the amount exceeds \$10,000. Before you designate a minor as your beneficiary, you should consult an attorney or professional financial advisor.

**Designating an institution as beneficiary** – To designate an institution (church, charity, funeral home, etc.) as your beneficiary, provide the full name of the institution and list the address in the space provided.

**After you complete and sign the Beneficiary Designation Form, mail it to:**

**Office of Management and Enterprise Services  
Employees Group Insurance Division  
P.O. Box 11137, Oklahoma City, OK 73136-9998**

**Remember to keep a copy of your completed form for your records.**



**State of Oklahoma**  
**Office of Management and Enterprise Services**  
**Privacy Notice**  
**Revised October 2023**

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.**

**For questions or complaints regarding privacy concerns with OMES, please contact:**

OMES HIPAA Privacy Officer  
P.O. Box 11137, Oklahoma City, OK 73136  
405-717-8780 or toll-free 800-752-9475  
TTY 711  
[oklahoma.gov/omes](http://oklahoma.gov/omes)

**Why is the notice of privacy practices important?**

This notice provides important information about the practices of OMES pertaining to the way it gathers, uses, discloses and manages your Protected Health Information and also describes how you can access this information. PHI is health information that can be linked to a particular person by certain identifiers including, but not limited to, names, Social Security numbers, addresses and birth dates.

Oklahoma privacy laws and the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) protect the privacy of an individual's health information. Please note, in general the laws and regulations of HIPAA do not apply to the Health Choice Disability Plan and HealthChoice Life Insurance Plan. For HIPAA purposes, OMES has designated itself as a hybrid entity. This means that HIPAA only applies to areas of OMES operations involving health care and not to all lines of service offered by OMES. This notice applies to the privacy practices of the following OMES divisions and positions that may share or access your PHI as needed for treatment, payment and health care operations:

- Employees Group Insurance Division (EGID).
- General Counsel Legal.
- Information Services as it applies to maintenance and storage of PHI.
- The Director of Public Affairs and Grants Management and the Legislative Liaison.

OMES is committed to protecting the privacy and security of your PHI as used within the components listed above.

## **Your information. Your rights. Our responsibilities.**

### **Your rights**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

#### **Get an electronic or paper copy of your health and claims records.**

- You can ask to see or get an electronic copy of your medical record and other health information we have about you. Ask us how to do this using the contact information at the beginning of this notice.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

#### **Ask us to correct health and claims records.**

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this using the contact information at the beginning of this notice.
- We may decline your request but will explain the reasons in writing within 60 days.

#### **Request confidential communications.**

- You can ask us to contact you in a specific manner; e.g., home or office phone, or to send mail to an alternate address.
- We will consider all reasonable requests.
  - If declining would put you in danger, tell us and we will automatically approve your request.

#### **Ask us to limit what we use or share.**

- You can ask us not to use or share certain health information for treatment, payment or our operations.
  - We are not required to approve your request and may decline if it would affect your care.

#### **Get a list of those with whom we've shared information.**

- You can ask for an accounting of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why.
- We will include all the disclosures except for those about treatment, payment and health care operations, and certain other disclosures (such as any you asked us to make).
- We will provide one free accounting per year but will charge a reasonable fee if you request an additional accounting within 12 months.

#### **Get a copy of this privacy notice.**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will promptly provide you with a paper copy.

### **Choose someone to act for you.**

- If you have named a medical power of attorney, or if someone is your legal guardian, that person can exercise your rights and make decisions about your health information.
- We will verify the person has this authority and can act for you before any action is taken.

### **File a complaint if you feel your rights are violated.**

- You can file a complaint if you feel we have violated your rights by contacting us using the information at the beginning of this notice.
- You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave., S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [hhs.gov/ocr/privacy/hipaa/complaints/](https://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

### **Your choices**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care.
- Share information in a disaster relief situation.
- Contact you for fundraising efforts.

If you are not able to tell us your preference (e.g., if you are unconscious), we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent health or safety threat.

In these cases, we *never* share your information unless you give us written permission:

- Marketing purposes.
- Sale of your information.
- Most sharing of psychotherapy notes.

### **Our uses and disclosures**

#### **How do we typically use or share your health information?**

Your PHI is used and disclosed by OMES employees and other entities under contract with OMES according to HIPAA Privacy Rules and the “minimum necessary” standard, which releases only the minimum necessary health information to achieve the intended purpose or to carry out a desired function within OMES.

We typically use or share your health information in the following ways:

**Help manage the health care treatment you receive.**

- We can use your health information and share it with professionals who are treating you.

*Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

**Run our organization.**

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

*Examples: We use health information about you to develop better services for you, provide customer service, resolve member grievances, member advocacy, conduct activities to improve member health and reduce costs, assist in the coordination and continuity of health care, and to set premium rates.*

**Pay for your health services.**

- We can use and disclose your health information as we pay for your eligible health services.

*Example: We share information about you with your dental plan to coordinate payment for your dental work.*

**Administer your plan.**

- We may disclose summarized health information to your health plan sponsor for plan administration.

*Example: Your employer contracts with us to provide a health plan, and we provide the employer with certain statistics to explain the premiums we charge.*

**How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must comply with the law to share your information for these purposes. For more information, refer to <https://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html>.

**Help with public health and safety issues.**

We can share your health information for certain situations such as:

- Preventing disease.
- Helping with product recalls.
- Reporting adverse reactions to medications.
- Reporting suspected abuse, neglect or domestic violence.
- Preventing or reducing a serious threat to anyone's health or safety.

**Do research.**

We can use or share your information for health research, as permitted by law.

**Comply with the law.**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to ensure we are complying with federal privacy laws.

**Respond to organ and tissue donation requests.**

We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director.**

We can share health information with a coroner, medical examiner or funeral director when an individual dies.

**Address workers' compensation, law enforcement and other government requests.**

We can use or share health information about you:

- For workers' compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.
- For special government functions such as military, national security, and presidential protective services.

**Respond to lawsuits and legal actions.**

We can share health information about you in response to a court or administrative order or in response to a subpoena.

**Our responsibilities****When it comes to your health information, we have specific obligations such as:**

- We are required by law to maintain the privacy and security of your Protected Health Information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your PHI.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your PHI other than as described here unless you notify us in writing that we can. You may change your mind at any time but must let us know in writing if you do.

For more information, refer to

<https://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html>.

**Changes to the terms of this notice.**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will deliver a copy to you. You may also subscribe online to receive notice of changes to this page via email or text message.

# Contact Information

## *Health plans*

### **BCBS – BlueLincs**

855-609-5684  
bcbsok.com/state

### **CommunityCare**

918-594-5242 or 800-777-4890  
TDD/TTY 800-722-0353  
state.ccok.com

### **GlobalHealth Inc.**

405-280-5600 or 877-280-5600  
TTY 711  
GlobalHealth.com/Oklahoma/mystateplan

### **HealthChoice**

Medical  
800-323-4314  
TTY 711  
HealthChoiceOK.com

### **Pharmacy**

877-720-9375  
TTY 711  
Caremark.com

## *Health Plans – Medicare Supplement Plans*

### **BCBSOK Member Services**

833-418-0443  
TTY 711  
bcbsok.com/retiree-medicare-state

### **HealthChoice**

Medical  
800-323-4314  
TTY 711  
HealthChoiceOK.com

### **Pharmacy**

866-275-5253  
TTY 711  
Caremark.com

## *Health Plans – MAPD Plans*

### **BCBSOK Member Services**

833-418-0443  
TTY 711  
bcbsok.com/retiree-medicare-state

### **CommunityCare Senior Health Plan**

918-594-5323 or 800-642-8065  
TDD/TTY 800-722-0353  
stateshp.ccok.com

### **Generations by GlobalHealth**

Prospective Members:  
844-322-8322  
Current Members:  
405-280-5555 or 844-280-5555  
TTY 711  
GlobalHealth.com/Oklahoma/osr

### **Humana Group Medicare Customer Care**

Identify yourself as a retiree with the State of Oklahoma/EGID when calling as a prospective member.  
866-396-8810  
TTY 711  
7 a.m. to 8 p.m. CT  
your.humana.com/ok-medicare

## *Dental Plans*

### **BCBS – BlueCare**

855-609-5684  
Bcbsok.com/state/dental

### **Cigna Prepaid Dental**

800-244-6224  
Hearing-impaired relay 800-654-5988  
view.ceros.com/cigna/ok-ins-benefits

### **Delta Dental**

405-607-2100 or 800-522-0188  
DeltaDentalOK.org/client/OK



# Contact Information

## **HealthChoice**

Customer Care 800-323-4314  
TTY 711  
HealthChoiceOK.com

## **MetLife**

855-676-9443  
metlife.com/Oklahoma

## **Sun Life**

800-442-7742  
onboard.sunlifeconnect.com

## ***Life Plans***

## **HealthChoice**

Customer Care 800-323-4314  
TTY 711  
HealthChoiceOK.com

## ***Vision plans***

## **Primary Vision Care Services (PVCS)**

888-357-6912  
TDD 800-722-0353  
pvcs-usa.com/okstate

## **Superior Vision**

800-507-3800  
TDD 916-852-2382  
superiorvision.com/stateofoklahoma/benefits

## **Vision Care Direct**

855-918-2020  
TTY 711  
okstate.vision

## **VSP**

800-877-7195  
TDD 800-428-4833  
stateofok.vspforme.com

## ***Other important numbers***

## **Employees Group Insurance Division**

405-717-8780 or 800-752-9475  
TTY 711  
Oklahoma.gov/omes

## **Social Security Administration**

800-772-1213  
TTY 800-325-0778  
SSA.gov

## **Medicare**

800-633-4227  
TTY 877-486-2048  
Medicare.gov

## **Oklahoma Public Employees Retirement System**

405-858-6737 or 800-733-9008  
opers.ok.gov

## **Oklahoma Teachers' Retirement System**

405-521-2387 or 877-738-6365  
ok.gov/trs

## **Oklahoma Law Enforcement Retirement System**

405-522-4931 or 877-213-0856  
olers.state.ok.us

## Forms you must complete to continue benefits when you leave active employment

INSURANCE FORMS	IF YOU ARE A PRE-MEDICARE MEMBER	IF YOU ARE A MEMBER ENROLLING IN A MEDICARE SUPPLEMENT PLAN	IF YOU ARE A MEMBER ENROLLING IN A MEDICARE ADVANTAGE PRESCRIPTION DRUG (MAPD) PLAN
Application for Retiree/Vested/Non- Vested/Defer Insurance Coverage (Page A1)	Yes	Yes	Yes
Application for Medicare Supplement With Prescription Drug Plan (Page B1)	No	Yes Each enrollee must complete an application	No
Application for Medicare Advantage Prescription Drug (MAPD) Plan (Page C1)	No	No	Yes Each enrollee must complete an application
Beneficiary Designation Form (If continuing life insurance coverage) (Page E1)	Yes	Yes	Yes





**OKLAHOMA**  
Office of Management  
& Enterprise Services