OKLAHOMA
Employees Group Insurance Division

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2025 OPTION PERIOD ENROLLMENT/CHANGE FORM

COBRA MEDICARE MEMBERS

If not making changes, do not return this form. All changes are effective Jan. 1, 2025

Member information

Member name (First MI Last)		Member ID/SSN
Date of birth	☐ Male ☐ Female	☐ Married ☐ Single
Mailing address (☐ New)	City State ZIP code	
Phone	Alt phone	Email

NOTE: You and your dependents must all have coverage under the same plan. For example, if you are enrolled in a HealthChoice or an HMO plan, your covered dependents must also be enrolled in HealthChoice or that HMO plan.

Medicare health plan election – Select a plan to add or change

☐ **No change** ☐ **Add or change** ☐ **Drop**

☐ BCBSOK – BlueSecure
☐ BCBSOK – MAPD
☐ CommunityCare Senior Health Plan
☐ Generations by GlobalHealth
☐ Humana MAPD PPO
☐ High ☐ Low HealthChoice SilverScript Medicare Supplement Plan

If enrolling in or changing to a different Medicare plan with EGID, you and/or your dependents must also complete a Medicare Part D application and return it with this form.

Pre-Medicare health plan election – Select a plan to add or change

☐ **No change** ☐ **Add or change** ☐ **Drop**

☐ BCBSOK – BlueLincs HMO
☐ CommunityCare HMO
☐ GlobalHealth HMO
☐ HealthChoice High Deductible Health Plan (HDHP)
☐ HealthChoice High* or High Alternative
☐ HealthChoice Basic* or Basic Alternative
*Must complete online Tobacco-Free Attestation or reasonable alternative by Dec. 31, 2024.

Name of member's primary physician (HMO only):

☐ Current patient ☐ New patient

Dental plan election – Select a plan to add or change

☐ **No change** ☐ **Add or change** ☐ **Drop**

☐ BCBSOK BlueCare Dental High Plan
☐ BCBSOK BlueCare Dental Low Plan
☐ Cigna Prepaid High (K1I09)
☐ Cigna Prepaid Low (OKIV9)
☐ Delta Dental PPO – Choice
☐ Delta Dental PPO
☐ HealthChoice Dental
☐ MetLife High Classic MAC
☐ MetLife Low Classic MAC
☐ Sun Life Preferred Active PPO

Name of member's primary dentist (Prepaid only):

☐ Current patient ☐ New patient

Vision plan election – Select a plan to add or change

☐ **No change** ☐ **Add or change** ☐ **Drop**

☐ Primary Vision Care Services (PVCS)
☐ Superior Vision
☐ Vision Care Direct
☐ VSP (Vision Service Plan)

Dependent elections

Spouse name ☐ Pre-Medicare ☐ Medicare		Health ☐ **Add** ☐ **Drop** Vision ☐ **Add** ☐ **Drop** Dental ☐ **Add** ☐ **Drop**
SSN		Primary physician ☐ Current patient ☐ New patient
Date of birth	☐ Male ☐ Female	Primary dentist ☐ Current patient ☐ New patient
Child name ☐ Pre-Medicare ☐ Medicare		Health ☐ **Add** ☐ **Drop** Vision ☐ **Add** ☐ **Drop** Dental ☐ **Add** ☐ **Drop**
SSN		Primary physician ☐ Current patient ☐ New patient
Date of birth	☐ Male ☐ Female	Primary dentist ☐ Current patient ☐ New patient
Child name ☐ Pre-Medicare ☐ Medicare		Health ☐ **Add** ☐ **Drop** Vision ☐ **Add** ☐ **Drop** Dental ☐ **Add** ☐ **Drop**
SSN		Primary physician ☐ Current patient ☐ New patient
Date of birth	☐ Male ☐ Female	Primary dentist ☐ Current patient ☐ New patient
Child name ☐ Pre-Medicare ☐ Medicare		Health ☐ **Add** ☐ **Drop** Vision ☐ **Add** ☐ **Drop** Dental ☐ **Add** ☐ **Drop**
SSN		Primary physician ☐ Current patient ☐ New patient
Date of birth	☐ Male ☐ Female	Primary dentist ☐ Current patient ☐ New patient

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

Signatures

Member signature	Date

You must sign and date this form.

If enrolling in or changing to a different Medicare plan with EGID, you and/or your Medicare-eligible dependents must complete a Medicare Part D application in addition to this form and return them to EGID.

If you are not making changes, do not return this form.

If making changes, return completed form(s) no later than Dec. 7, 2024, to:
EGID
P.O. Box 11137
Oklahoma City, OK 73136-9998