



**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	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Married	<input type="checkbox"/> Single
Mailing address ( <input type="checkbox"/> New)		City	State	ZIP code
Phone	Alt phone		Email	

**CAUTION:** If you drop your health or dental coverage or drop or reduce your life insurance coverage, you cannot regain this coverage in the future. This also applies to your dependents unless they lose other coverage.

**Medicare health plan election – Select a plan to change**

- No change**       **Change**       **Drop all health coverage**
- BCBSOK – BlueSecure       Generations by GlobalHealth  
 BCBSOK – MAPD       Humana MAPD PPO  
 CommunityCare Senior Health Plan       High     Low    HealthChoice SilverScript Medicare Supplement Plan

If enrolling in or changing to a different Medicare plan, 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 change**

- No change**       **Change**       **Drop**
- BCBSOK – BlueLincs HMO       HealthChoice High\* or High Alternative  
 CommunityCare HMO       HealthChoice Basic\* or Basic Alternative  
 GlobalHealth HMO      \*Must complete online Tobacco-Free Attestation or  
 HealthChoice High Deductible Health Plan (HDHP)      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 change**

- No change**       **Change**       **Drop**
- BCBSOK BlueCare Dental High Plan       Delta Dental PPO  
 BCBSOK BlueCare Dental Low Plan       HealthChoice Dental  
 Cigna Prepaid High (K1I09)       MetLife High Classic MAC  
 Cigna Prepaid Low (OKIV9)       MetLife Low Classic MAC  
 Delta Dental PPO – Choice       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)       Vision Care Direct  
 Superior Vision       VSP (Vision Service Plan)

**Member Life plan election (decreasing is in \$5,000 units)**

- No change**     **Drop**     **Decrease total Member Life insurance to: \$ \_\_\_\_\_**

**Dependent elections (decreasing Dependent Life is in \$5,000 units)**

Spouse name <input type="checkbox"/> Pre-Medicare <input type="checkbox"/> Medicare		Health <input type="checkbox"/> <b>Drop</b>	Vision <input type="checkbox"/> <b>Add</b> <input type="checkbox"/> <b>Drop</b>
		Dental <input type="checkbox"/> <b>Drop</b>	Dependent Life <input type="checkbox"/> <b>Drop</b>
		Decrease Dependent Life to: \$	
SSN		Primary physician <input type="checkbox"/> Current patient <input type="checkbox"/> New patient	
Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Primary dentist <input type="checkbox"/> Current patient <input type="checkbox"/> New patient	
Child name <input type="checkbox"/> Pre-Medicare <input type="checkbox"/> Medicare		Health <input type="checkbox"/> <b>Drop</b>	Vision <input type="checkbox"/> <b>Add</b> <input type="checkbox"/> <b>Drop</b>
		Dental <input type="checkbox"/> <b>Drop</b>	Dependent Life <input type="checkbox"/> <b>Drop</b>
		Decrease Dependent Life to: \$	
SSN		Primary physician <input type="checkbox"/> Current patient <input type="checkbox"/> New patient	
Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Primary dentist <input type="checkbox"/> Current patient <input type="checkbox"/> New patient	
Child name <input type="checkbox"/> Pre-Medicare <input type="checkbox"/> Medicare		Health <input type="checkbox"/> <b>Drop</b>	Vision <input type="checkbox"/> <b>Add</b> <input type="checkbox"/> <b>Drop</b>
		Dental <input type="checkbox"/> <b>Drop</b>	Dependent Life <input type="checkbox"/> <b>Drop</b>
		Decrease Dependent Life to: \$	
SSN		Primary physician <input type="checkbox"/> Current patient <input type="checkbox"/> New patient	
Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Primary dentist <input type="checkbox"/> Current patient <input type="checkbox"/> New patient	
Child name <input type="checkbox"/> Pre-Medicare <input type="checkbox"/> Medicare		Health <input type="checkbox"/> <b>Drop</b>	Vision <input type="checkbox"/> <b>Add</b> <input type="checkbox"/> <b>Drop</b>
		Dental <input type="checkbox"/> <b>Drop</b>	Dependent Life <input type="checkbox"/> <b>Drop</b>
		Decrease Dependent Life to: \$	
SSN		Primary physician <input type="checkbox"/> Current patient <input type="checkbox"/> New patient	
Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Primary dentist <input type="checkbox"/> Current patient <input type="checkbox"/> New patient	

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

**Signatures**

Member signature	Date
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**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
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**If making changes, return completed form(s) no later than Dec. 7, 2024, to:**

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