Office of Management and Enterprise Services
Employees Group Insurance Division
TRICARE SUPPLEMENT ENROLLMENT FORM

EMPLOYER INFORMATION (To be completed by insurance coordinator.)

Group ID#_____ **Division ID#** _____ **Group Name** _____

☐ New Hire Enrollment ☐ Option Period ☐ Midyear Enrollment

EMPLOYEE INFORMATION (Please print)

SSN or Member ID# _____ ☐ Married ☐ Single

Employee's Name	**First Name**	**M.I.**	**Last Name**
Please Print			

Mailing Address_____

_____
City **State** **ZIP Code**

Home Telephone # _____ Email Address_____

Employee's Birth Date	Mo.	Day	Yr.	Sex
				☐M ☐F

Effective Date of Coverage	Mo.	Day	Yr.
		0 1	

EMPLOYEE HEALTH PLAN ELECTION

NOTE: ***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 age 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 primarily responsible for your medical coverage and the supplement plan will be secondarily responsible for 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.**

☐ TRICARE Supplement Plan

FOR EGID USE ONLY

DEPENDENT INFORMATION

SPOUSE* ☐ Health — Name _____ SSN _____
Date of Birth _____ ☐ Male ☐ Female
Primary Physician _____ ☐ Current Patient ☐ New Patient
Primary Dentist _____ ☐ Current Patient ☐ New Patient

***Does your spouse currently have health, dental and/or vision coverage through EGID? ☐ Yes ☐ No (If Yes, list name and SSN above)**

CHILD ☐ Health — Name _____ SSN _____
Date of Birth _____ ☐ Male ☐ Female
Primary Physician _____ ☐ Current Patient ☐ New Patient
Primary Dentist _____ ☐ Current Patient ☐ New Patient

CHILD ☐ Health — Name _____ SSN _____
Date of Birth _____ ☐ Male ☐ Female
Primary Physician _____ ☐ Current Patient ☐ New Patient
Primary Dentist _____ ☐ Current Patient ☐ New Patient

CHILD ☐ Health — Name _____ SSN _____
Date of Birth _____ ☐ Male ☐ Female
Primary Physician _____ ☐ Current Patient ☐ New Patient
Primary Dentist _____ ☐ Current Patient ☐ New Patient

PLEASE USE THE DEPENDENT ATTACHMENT FORM TO LIST ADDITIONAL DEPENDENTS
(This form is available from your insurance coordinator.)

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

Employee Signature _____ **Date** _____

SPOUSE MUST SIGN IF COMMON-LAW OR EXCLUDED FROM HEALTH AND/OR DENTAL COVERAGE.

☐ **COMMON-LAW SPOUSE CERTIFICATION:** I certify that 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, and that 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** (required only if children are covered and spouse is not)**:** I certify I am aware **I am being excluded from health and/or dental coverage as indicated on this form.** I am also aware that an employee who elects to cover all eligible dependent children and NOT their spouse will not have the opportunity to enroll their spouse until either the next annual Option Period or a midyear qualifying event occurs.

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, is in compliance with new hire or allowed midyear coverage enrollments as defined by Title 26, Section 125, of the Internal Revenue Codes (as amended) and pertinent regulations.

Insurance Coordinator's Signature _____ **Date** _____
(Must be signed by insurance coordinator to be valid.)