Office of Management and Enterprise Services Employees Group Insurance Department
2017 OPTION PERIOD ENROLLMENT/CHANGE FORM
CURRENT EMPLOYEE
THIS FORM MUST BE RETURNED TO YOUR INSURANCE COORDINATOR

SECTION A: EMPLOYEE INFORMATION   (Please Print)

Group ID# _____ Division ID# _____ Group Name _____

Member Name _____ SSN or Member ID# _____
               First Name   **MI**   **Last Name**

Gender ☐ Male ☐ Female   _____/_____/_____   ☐ Married ☐ Single
                                     Birth Date

Mailing Address _____ Phone _____-_____-_____
☐ **New Address**

_____ Alt Phone _____- _____-_____
          City   **State**   **ZIP Code**

Email Address _____

SECTION B: ALL CHANGES ARE EFFECTIVE JAN. 1, 2017
See back side of form for required signatures and enrollment or change to dependent coverage.

Health Plan
Check a box to ADD or CHANGE plans:

☐ HealthChoice High***** or High Alternative (refer to Option Period materials)
☐ HealthChoice Basic***** or Basic Alternative (refer to Option Period materials)
☐ HealthChoice High Deductible Health Plan (HDHP)
    *Requires completion of tobacco-free Attestation or Reasonable Alternative.

☐ No Change   ☐ Aetna HMO   ☐ CommunityCare HMO
☐ Drop All Health   ☐ GlobalHealth HMO

Employee Primary Physician (HMO Plans Only) _____ ☐ New Patient ☐ Current Patient

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Dental Plan

Check a box to ADD or CHANGE plans:

☐ No Change
☐ Drop All Dental

☐ Assurant Freedom Preferred   ☐ MetLife Classic
☐ Assurant Heritage Plus w/SBA (Prepaid) ☐ MetLife Value MAC
☐ Assurant Heritage Secure (Prepaid)   ☐ MetLife Value PDP
☐ CIGNA Dental Care Plan (Prepaid)
☐ Delta Dental PPO   _____
☐ Delta Dental PPO – Choice   Employee Primary Dentist
☐ Delta Dental PPO Plus Premier   (Prepaid Plans Only)
☐ HealthChoice Dental Plan   ☐ New Patient ☐ Current Patient

Vision Plan
Check a box to ADD or CHANGE plans:

☐ No Change
☐ Drop All Vision

☐ Primary Vision Care Services
☐ Superior Vision
☐ Vision Care Direct
☐ Vision Service Plan

Employee Life Plan
Employee life CANNOT be added or increased using this form.
A separate "Life Insurance Application" must be completed and
approved to add or increase life insurance coverage.

☐ No Change ☐ Drop All Life Insurance

☐ Decrease total life insurance to: $ _____
  (Keep employee life in $20,000 units)

☐ **I have added or made changes on the back of this form for my dependents.**

Dependent Life Plan (Employee Life Required)
☐ No Change
☐ Drop Dependent Life
☐ Add or Increase to Premier Option
☐ Add or Increase/Decrease to Standard Option
☐ Add or Decrease to Low Option

FOR IC USE ONLY	**FOR EGID USE ONLY**

SPOUSE*

Add	**Drop**			
☐	☐	Health	Name _____	SSN _____
☐	☐	Dental	Date of Birth _____	☐ Male ☐ Female
☐	☐	Vision	Primary Physician _____	☐ New Patient ☐ Current Patient
☐	☐	Dependent Life	Primary Dentist _____	☐ New Patient ☐ Current Patient

* Does your spouse currently have coverage through EGID? ☐ Yes ☐ No (If yes, list name and SSN above)

CHILD

Add	**Drop**			
☐	☐	Health	Name _____	SSN _____
☐	☐	Dental	Date of Birth _____	☐ Male ☐ Female
☐	☐	Vision	Primary Physician _____	☐ New Patient ☐ Current Patient
☐	☐	Dependent Life	Primary Dentist _____	☐ New Patient ☐ Current Patient

CHILD

Add	**Drop**			
☐	☐	Health	Name _____	SSN _____
☐	☐	Dental	Date of Birth _____	☐ Male ☐ Female
☐	☐	Vision	Primary Physician _____	☐ New Patient ☐ Current Patient
☐	☐	Dependent Life	Primary Dentist _____	☐ New Patient ☐ Current Patient

CHILD

Add	**Drop**			
☐	☐	Health	Name _____	SSN _____
☐	☐	Dental	Date of Birth _____	☐ Male ☐ Female
☐	☐	Vision	Primary Physician _____	☐ New Patient ☐ Current Patient
☐	☐	Dependent Life	Primary Dentist _____	☐ New Patient ☐ Current Patient

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

SECTION D: CERTIFICATION SIGNATURES

Employee Signature _____ **Date** _____

YOUR SPOUSE MUST SIGN IF THEY ARE 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 that 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 change of status event occurs.

Spouse Signature _____ **Date** _____