New Hire Form

EMPLOYEES BENEFITS COUNCIL

Plan Information is available at *www.ebc.state.ok.us*

1 Employee Information Please Print or Type

SSN		
Last Name	First Name	Middle Name
Home Mailing Address	City	State Zip
Home Phone ( )	Date of Birth	☐ Married ☐ Single ☐ M ☐ F

2 Hiring Agency Agency Name Agency # / Location #

Date Employed	Date Benefits Effective / 01 /	Work Phone ( )
Pay Frequency ☐ 12 ☐ 24 ☐ 26	Retirement System ☐ OPERS ☐ TEACHERS ☐ OLERS ☐ JUDICIAL ☐ WILDLIFE	

3 Premium Conversion Provides tax savings on eligible premiums. Enrollment is automatic unless you check the "NO" box. Available for Military Opt Out. ☐ No = All Premiums taxed

4 Retired Military Retired Military may opt out of some or all coverage but must complete the Retired Military Opt Out Form, provide required documentation, and attach to this form. See Benefits Coordinator for form and information. Opt Out ☐ All Required Benefits

5 Health Insurance Plan Name & Option Level ☐ HMO Authorized Zip HMO applicants select Primary Care Physician

6 Dental Insurance Plan Name ☐ DMO DMO applicants select Primary Care Dentist

7 Vision Insurance Available for Military Opt Out ☐ Yes ☐ No ☐ Employee Only ☐ Employee & Family Plan Name

8 Supplemental Life Insurance Annual Salary $ _____ (required for supplemental life in excess of $20,000 Basic)

Basic & Supp Life can only be added as a New Hire employee, during Option Period, or within thirty (30) days after losing other group life insurance. The Supplemental Life Guaranteed Issue (GI) amount equals two (2) times your yearly salary rounded up to the next $20,000 increment. The maximum Supplemental Life Insurance allowed [including guaranteed issue], can only equal five (5) times your yearly salary rounded up to the next $20,000 increment & may not exceed $300,000. Amounts requested over your GI require completion of a separate Life Insurance Application Form.

☒ Basic (required)	$ 20,000
☐ Guaranteed Issue (2x annual salary at time of employment)	$
☐ Supplemental Life AGI	$
TOTAL	$

9 Dependent Life Insurance ☐ Yes ☐ No If Yes, Select Option ☐ Premier ☐ Standard ☐ Low

10 Flexible Spending Accounts **(Available for Military Opt Out)** ☐ Enroll for FREE Debit Card (only for use with Flexible Spending Accounts)

		Per Pay Period	None
☐ Dependent Care Account	Monthly minimum=$50, Monthly maximum = $416.66	$	☐
☐ Health Care Account	Monthly minimum=$10, Monthly maximum = $416.66	$	☐
☐ Mass Transportation Account	Monthly minimum=$10, Monthly maximum = $115.00	$	☐

For information about the Okhealth Mentoring Program go to: www.ebc.state.ok.us/en/OKHealth

11 Employee Authorization

I authorize and agree to any NECESSARY salary reduction to implement my elections. I UNDERSTAND MY ELECTIONS ARE BINDING AND IRREVOCABLE AND WILL REMAIN IN EFFECT FOR THE FULL PLAN YEAR UNLESS I EXPERIENCE AN ALLOWABLE MIDYEAR CHANGE EVENT. I understand that I have 30 days from the event to request any applicable changes to my options for this Plan Year. I also understand that any money left in the reimbursement account(s) will be forfeited at the end of the Plan Year grace period or upon my termination with the State

Employee Signature _____ **Date** _____ **Agency#** / **Location#** _____

Change cont. Last name _____ Date _____ SSN _____

12 Dependent Information Complete and check coverage boxes

Spouse

☐ Add Health
☐ Add Dental
☐ Add Vision
☐ Add Dep Life

Name | SSN

Date of Birth ☐ M ☐ F

Address | City | State | Zip

Primary Care Physician

Primary Care Dentist

Child

☐ Add Health
☐ Add Dental
☐ Add Vision
☐ Add Dep Life

Name | SSN

Date of Birth ☐ M ☐ F

Address | City | State | Zip

Primary Care Physician

Primary Care Dentist

Child

☐ Add Health
☐ Add Dental
☐ Add Vision
☐ Add Dep Life

Name | SSN

Date of Birth ☐ M ☐ F

Address | City | State | Zip

Primary Care Physician

Primary Care Dentist

13 Have you or your spouse previously been a permanent employee of one of the following?

		Final Employment Date
☐ OK State ☐ Edu-cation ☐ County	Organization Name (Self)	
☐ OK State ☐ Edu-cation ☐ County	Organization Name (Spouse)	

14 Are you or any of your dependents covered under other group coverage?

			Final Employment Date
Organization Name (Self)		☐ HIPAA Certificate?	
Organization Name (Dependent)	Insured Name (Dependent)	☐ HIPAA Certificate?	

15 Declining Coverage for Dependents

If you are declining enrollment for your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll your dependents in this plan if your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependents' other coverage). However, you must request enrollment within thirty (30) days after your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your dependents. However, you must request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Employees Benefits Council at (405) 232-1190 or (800) 219-8115.

Employee Signature Date

X _____ _____

My signature above represents that I am declining health coverage on my eligible dependents.

16 Benefits Coordinator Authorization, please date & sign.

This original enrollment form must be sent to EBC with any additional required enrollment documentation (i.e. Exclusion for Spouse Coverage, other group coverage proof, Life Insurance Applications, etc.). An incomplete form (by employee or Coordinator) will be returned resulting in a processing delay and/or denial of claims.

Benefits Coordinator Phone ( ) Date

X _____ _____ _____

BC Email

_____

IMPORTANT! Send Original form and all attachments to the Employees Benefits Council

EBC/Change 12/03/2008

Print Form with Information **Clear Form**