OKLAHOMA
Office of Management
& Enterprise Services

Human Capital Management
Employee Benefits Department

EMPLOYEE OPT-OUT ACCEPTANCE

2401 N. Lincoln Blvd., Oklahoma City, OK 73105 – Phone: 405-522-5528 or 800-219-8115

I, _____, understand I am opting out of the basic plan of benefits (health, dental, disability and Basic Life); or, I may retain my life and disability benefits by opting out of health and dental only:

☐ Basic plan (health, dental, disability and Basic Life).

☐ Health and dental only.

By opting out of the above benefits, I understand I will not receive the state-provided benefits allowance I would otherwise be eligible to receive. I will receive a monthly amount of $150 (or the biweekly equivalent) in lieu of the flexible benefits allowance. **Employee may still choose premium conversion, vision coverage and the flexible spending accounts.**

By signing this form, I attest I am eligible to participate and I am either currently covered by a separate group health insurance plan or will be covered by a separate group health insurance plan at or before the beginning of the next plan year and shall provide proof of the separate health insurance plan participation. **If I did NOT opt out in the previous plan year** and the documentation is not provided before the beginning of the new plan year, I understand I will be enrolled in the previous plan year's election excluding the FSAs.

Employees opting out who have retired from military service and have federal TRICARE insurance benefits are required to provide a copy (both sides) of your DD Form 2 (Retired).

I understand in order to continue my election of the benefits stated above for subsequent plan years, I must reapply for the opt-out provision each year. **If I had elected to opt-out in the previous plan year** and fail to sign both the Employee Opt-Out Acceptance and the Option Period Enrollment Form, and fail to provide the required proof, I will be re-enrolled under the following plans: HealthChoice High Option Medical, HealthChoice Dental, Basic Life Insurance and Disability Insurance.

Agency name _____ **Agency # and location code** _____

Employee name _____ **SSN** _____
(Print)

Employee signature _____ **Date** _____

Benefits coordinator _____ **Date** _____

Print Form with Information | Clear Form