OKLAHOMA
Office of Management
& Enterprise Services

Human Capital Management
Employee Benefits Department

PLAN YEAR 2021 OPTION PERIOD ENROLLMENT FORM

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

Current plan year ends Dec. 31, 2020
Next plan year begins Jan. 1, 2021, and ends Dec. 31, 2021
Pay frequency _____ (monthly, biweekly)
Agency _____
Employee ID _____
Social Security number _____
Employee name _____
Birthdate _____
Address _____
☐ Change _____

Section A (for enrollment)

Premium conversion

Next plan year choice:

☐ **Yes** ☐ **No***

*No = No tax savings on eligible premiums.

Health plan election

Next plan year choice:

- ☐ **BlueLincs HMO***
- ☐ **CommunityCare HMO***
- ☐ **GlobalHealth HMO***
- ☐ **HealthChoice High**
- ☐ **HealthChoice Basic**
- ☐ **HealthChoice High Alternative**
- ☐ **HealthChoice Basic Alternative**
- ☐ **HealthChoice HDHP**

**List PCP only if you are switching to an HMO or changing HMOs for Jan. 1.*

Employee PCP for HMO _____

(If spouse or child's PCP is different or if adding or dropping dependents, indicate on Section B.)

Dental plan election

Next plan year choice:

- ☐ **BCBSOK – BlueCare Dental High Plan**
- ☐ **BCBSOK – BlueCare Dental Low Plan**
- ☐ **Cigna Prepaid High (K1I09)***
- ☐ **Cigna Prepaid Low (OKIV9)***
- ☐ **Delta Dental PPO**
- ☐ **Delta Dental PPO – Choice**
- ☐ **HealthChoice Dental**
- ☐ **MetLife High Classic MAC**
- ☐ **MetLife Low Classic MAC**
- ☐ **Sun Life Preferred Active PPO**

***List employee PCD** _____

(If spouse or child's PCD is different, indicate on Section B.)

Vision plan election

Next plan year choice:

- ☐ **NO CHANGE**
- ☐ **DROP ALL**
- ☐ **CHANGE**
- ☐ **Employee**
- ☐ **PVCS**
- ☐ **Superior Vision**
- ☐ **Dependents** (must name in Section B)
- ☐ **Vision Care Direct**
- ☐ **VSP**

Supplemental Life

Next plan year choice: ❑ **NO CHANGE** ❑ **DROP ALL** ❑ **CHANGE** $ _____ **amount**

(To reduce or increase, ask your benefits coordinator for required forms.)

Dependent Life

(For family members*)

Next plan year choice: ❑ **NO CHANGE** ❑ **DROP ALL** ❑ **CHANGE**

Choose: ❑ **PREMIER OPTION** ❑ **STANDARD OPTION** ❑ **LOW OPTION**

*Must name dependents on Section B for coverage.

Flexible spending account

Current participants must re-enroll to continue coverage and use of debit card. By using the card, you hereby renew your My Use of Card Promises included with your card.

Next plan year choice:

Health care account

(Enrollment not available if electing HealthChoice HDHP account.)

❑ **None** $ _____ **(per pay period)** $ _____ **(per plan year)**

Dependent day care account

❑ **None** $ _____ **(per pay period)** $ _____ **(per plan year)**

Health savings account

(Use with the High Deductible Health Plan.)

❑ **None** $ _____ **(per pay period)** $ _____ **(per plan year)**

Opt out of core benefits (health, dental, disability and Basic Life) including any Supplemental Life or Dependent Life, or health and dental only (requires an Employee Opt-Out Acceptance form).

❑ **Opt out of all core benefits.** ❑ **Opt out of health and dental only.**

❑ **Elect TRICARE Supplement.**

IMPORTANT: PLEASE READ AND SIGN.

I hereby authorize and agree to a salary reduction, if necessary, to implement my benefits elections. I understand my benefit elections are binding, irrevocable and effective for the entire plan year unless I experience an allowable midyear change. I further understand I must notify the Employees Benefits Department of HCM within 30 days after a midyear change to give effect to the change. The elections I now submit revoke and supersede all previous benefits elections. I understand any remaining funds in the spending accounts after the end of the plan year will be forfeited upon my termination with the state.

Employee signature _____ **Date** _____

Section B (Dependents/options to be added or dropped)

1. Do NOT list dependents currently covered under health, dental, vision and Dependent Life, if you wish to keep them covered for the new plan year. The system will roll prior dependent elections over into the 2021 plan year. Only list dependents you want to ADD or DROP from health, dental, vision and Dependent Life.
2. Do NOT list a PCP unless you are switching to an HMO or changing HMOs for the new plan year.
3. Do NOT list a PCD unless you are switching to a prepaid dental plan.

For all midyear changes to PCP or PCD, call the HMO or dental plan.

Spouse: **Health** ___ Add ___ Drop **Dental** ___ Add ___ Drop **Vision** ___ Add ___ Drop **Dep. Life** ___ Add ___ Drop	Name ______________ Date of birth ______________ Social Security number ______________ ______ Male ______ Female Address ______________ ______________ Primary care physician ______________ Primary care dentist ______________
Child: **Health** ___ Add ___ Drop **Dental** ___ Add ___ Drop **Vision** ___ Add ___ Drop **Dep. Life** ___ Add ___ Drop	Name ______________ Date of birth ______________ Social Security number ______________ ______ Male ______ Female Address ______________ ______________ Primary care physician ______________ Primary care dentist ______________
Child: **Health** ___ Add ___ Drop **Dental** ___ Add ___ Drop **Vision** ___ Add ___ Drop **Dep. Life** ___ Add ___ Drop	Name ______________ Date of birth ______________ Social Security number ______________ ______ Male ______ Female Address ______________ ______________ Primary care physician ______________ Primary care dentist ______________
Child: **Health** ___ Add ___ Drop **Dental** ___ Add ___ Drop **Vision** ___ Add ___ Drop **Dep. Life** ___ Add ___ Drop	Name ______________ Date of birth ______________ Social Security number ______________ ______ Male ______ Female Address ______________ ______________ Primary care physician ______________ Primary care dentist ______________
Other: **Health** ___ Add ___ Drop **Dental** ___ Add ___ Drop **Vision** ___ Add ___ Drop **Dep. Life** ___ Add ___ Drop	Name ______________ Date of birth ______________ Social Security number ______________ ______ Male ______Female Address ______________ ______________ Primary care physician ______________ Primary care dentist ______________