



PLAN YEAR 2022 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, 2021
 Next plan year begins Jan. 1, 2022, and ends Dec. 31, 2022
 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:

<input type="checkbox"/> BlueLincs HMO*	<input type="checkbox"/> HealthChoice Basic
<input type="checkbox"/> CommunityCare HMO*	<input type="checkbox"/> HealthChoice High Alternative
<input type="checkbox"/> GlobalHealth HMO*	<input type="checkbox"/> HealthChoice Basic Alternative
<input type="checkbox"/> HealthChoice High	<input type="checkbox"/> 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:

<input type="checkbox"/> BCBSOK – BlueCare Dental High Plan	<input type="checkbox"/> Delta Dental PPO – Choice
<input type="checkbox"/> BCBSOK – BlueCare Dental Low Plan	<input type="checkbox"/> HealthChoice Dental
<input type="checkbox"/> Cigna Prepaid High (K1109)*	<input type="checkbox"/> MetLife High Classic MAC
<input type="checkbox"/> Cigna Prepaid Low (OKIV9)*	<input type="checkbox"/> MetLife Low Classic MAC
<input type="checkbox"/> Delta Dental PPO	<input type="checkbox"/> 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:

<input type="checkbox"/> NO CHANGE	<input type="checkbox"/> DROP ALL	<input type="checkbox"/> CHANGE
<input type="checkbox"/> Employee	<input type="checkbox"/> Dependents (must name in Section B)	
<input type="checkbox"/> PVCS	<input type="checkbox"/> Vision Care Direct	
<input type="checkbox"/> Superior Vision	<input type="checkbox"/> 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.

<p>Spouse:</p> <p>Health ___ Add ___ Drop</p> <p>Dental ___ Add ___ Drop</p> <p>Vision ___ Add ___ Drop</p> <p>Dep. Life ___ Add ___ Drop</p>	<p>Name _____ Date of birth _____</p> <p>Social Security number _____ Male _____ Female</p> <p>Address _____</p> <p>Primary care physician _____</p> <p>Primary care dentist _____</p>
<p>Child:</p> <p>Health ___ Add ___ Drop</p> <p>Dental ___ Add ___ Drop</p> <p>Vision ___ Add ___ Drop</p> <p>Dep. Life ___ Add ___ Drop</p>	<p>Name _____ Date of birth _____</p> <p>Social Security number _____ Male _____ Female</p> <p>Address _____</p> <p>Primary care physician _____</p> <p>Primary care dentist _____</p>
<p>Child:</p> <p>Health ___ Add ___ Drop</p> <p>Dental ___ Add ___ Drop</p> <p>Vision ___ Add ___ Drop</p> <p>Dep. Life ___ Add ___ Drop</p>	<p>Name _____ Date of birth _____</p> <p>Social Security number _____ Male _____ Female</p> <p>Address _____</p> <p>Primary care physician _____</p> <p>Primary care dentist _____</p>
<p>Child:</p> <p>Health ___ Add ___ Drop</p> <p>Dental ___ Add ___ Drop</p> <p>Vision ___ Add ___ Drop</p> <p>Dep. Life ___ Add ___ Drop</p>	<p>Name _____ Date of birth _____</p> <p>Social Security number _____ Male _____ Female</p> <p>Address _____</p> <p>Primary care physician _____</p> <p>Primary care dentist _____</p>
<p>Other:</p> <p>Health ___ Add ___ Drop</p> <p>Dental ___ Add ___ Drop</p> <p>Vision ___ Add ___ Drop</p> <p>Dep. Life ___ Add ___ Drop</p>	<p>Name _____ Date of birth _____</p> <p>Social Security number _____ Male _____ Female</p> <p>Address _____</p> <p>Primary care physician _____</p> <p>Primary care dentist _____</p>