

Dependent elections

Spouse name	<input type="checkbox"/> Pre-Medicare <input type="checkbox"/> Medicare	Health <input type="checkbox"/> Add <input type="checkbox"/> Drop Vision <input type="checkbox"/> Add <input type="checkbox"/> Drop Dental <input type="checkbox"/> Add <input type="checkbox"/> Drop
SSN		Primary physician <input type="checkbox"/> Current patient <input type="checkbox"/> New patient
Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Primary dentist <input type="checkbox"/> Current patient <input type="checkbox"/> New patient
Child name	<input type="checkbox"/> Pre-Medicare or <input type="checkbox"/> Medicare	Health <input type="checkbox"/> Add <input type="checkbox"/> Drop Vision <input type="checkbox"/> Add <input type="checkbox"/> Drop Dental <input type="checkbox"/> Add <input type="checkbox"/> Drop
SSN		Primary physician <input type="checkbox"/> Current patient <input type="checkbox"/> New patient
Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Primary dentist <input type="checkbox"/> Current patient <input type="checkbox"/> New patient
Child name	<input type="checkbox"/> Pre-Medicare <input type="checkbox"/> Medicare	Health <input type="checkbox"/> Add <input type="checkbox"/> Drop Vision <input type="checkbox"/> Add <input type="checkbox"/> Drop Dental <input type="checkbox"/> Add <input type="checkbox"/> Drop
SSN		Primary physician <input type="checkbox"/> Current patient <input type="checkbox"/> New patient
Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Primary dentist <input type="checkbox"/> Current patient <input type="checkbox"/> New patient
Child name	<input type="checkbox"/> Pre-Medicare <input type="checkbox"/> Medicare	Health <input type="checkbox"/> Add <input type="checkbox"/> Drop Vision <input type="checkbox"/> Add <input type="checkbox"/> Drop Dental <input type="checkbox"/> Add <input type="checkbox"/> Drop
SSN		Primary physician <input type="checkbox"/> Current patient <input type="checkbox"/> New patient
Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Primary dentist <input type="checkbox"/> Current patient <input type="checkbox"/> New patient

To list additional dependents, please obtain the Dependent Attachment Form from EGID.

Signatures

Member signature	Date
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You must sign and date this form.

If enrolling in or changing to a different Medicare plan with EGID, you and/or your Medicare-eligible dependents must complete a Medicare Part D application in addition to this form and return them to EGID.

If you are not making changes, do not return this form.

If making changes, return completed form(s) no later than Dec. 7, 2023, to:

OMES EGID
P.O. Box 11137
Oklahoma City, OK 73136-9998