



If not making changes, do not return this form. All changes are effective Jan. 1, 2025

Member information

Member name (First MI Last)			Member ID/SSN		
Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single			
Mailing address (<input type="checkbox"/> New)		City	State	ZIP code	
Phone	Alt phone	Email			

Health plan election – Select a plan to add or change

- No change**
 Add or change
 Drop
- | | |
|--|---|
| <input type="checkbox"/> BCBSOK – BlueLincs HMO | <input type="checkbox"/> HealthChoice High* or High Alternative |
| <input type="checkbox"/> CommunityCare HMO | <input type="checkbox"/> HealthChoice Basic* or Basic Alternative |
| <input type="checkbox"/> GlobalHealth HMO | *Must complete online Tobacco-Free Attestation or reasonable alternative by Dec. 31, 2024. |
| <input type="checkbox"/> HealthChoice High Deductible Health Plan (HDHP) | |

Member primary physician (HMO only):

- Current patient
 New patient

Dental plan election – Select a plan to add or change

- No change**
 Add or change
 Drop
- | | |
|---|--|
| <input type="checkbox"/> BCBSOK BlueCare Dental High Plan | <input type="checkbox"/> Delta Dental PPO |
| <input type="checkbox"/> BCBSOK BlueCare Dental Low Plan | <input type="checkbox"/> HealthChoice Dental |
| <input type="checkbox"/> Cigna Prepaid High (K1I09) | <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 – Choice | <input type="checkbox"/> Sun Life Preferred Active PPO |

Member primary dentist (Prepaid only):

- Current patient
 New patient

Vision plan election – Select a plan to add or change

- No change**
 Add or change
 Drop
- | | |
|--|--|
| <input type="checkbox"/> Primary Vision Care Services (PVCS) | <input type="checkbox"/> Vision Care Direct |
| <input type="checkbox"/> Superior Vision | <input type="checkbox"/> VSP (Vision Service Plan) |

Dependent elections

Spouse name		Health <input type="checkbox"/> Add <input type="checkbox"/> Drop	Dental <input type="checkbox"/> Add <input type="checkbox"/> Drop	Vision <input type="checkbox"/> Add <input type="checkbox"/> Drop
SSN		Primary physician <input type="checkbox"/> Current patient <input type="checkbox"/> New patient <input type="checkbox"/>		
Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Primary dentist <input type="checkbox"/> Current patient <input type="checkbox"/> New patient <input type="checkbox"/>		
Does your spouse have their own coverage through EGID? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, list name and SSN above.)				
Child name		Health <input type="checkbox"/> Add <input type="checkbox"/> Drop	Dental <input type="checkbox"/> Add <input type="checkbox"/> Drop	Vision <input type="checkbox"/> Add <input type="checkbox"/> Drop
SSN		Primary physician <input type="checkbox"/> Current patient <input type="checkbox"/> New patient <input type="checkbox"/>		
Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Primary dentist <input type="checkbox"/> Current patient <input type="checkbox"/> New patient <input type="checkbox"/>		
Child name		Health <input type="checkbox"/> Add <input type="checkbox"/> Drop	Dental <input type="checkbox"/> Add <input type="checkbox"/> Drop	Vision <input type="checkbox"/> Add <input type="checkbox"/> Drop
SSN		Primary physician <input type="checkbox"/> Current patient <input type="checkbox"/> New patient <input type="checkbox"/>		
Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Primary dentist <input type="checkbox"/> Current patient <input type="checkbox"/> New patient <input type="checkbox"/>		
Child name		Health <input type="checkbox"/> Add <input type="checkbox"/> Drop	Dental <input type="checkbox"/> Add <input type="checkbox"/> Drop	Vision <input type="checkbox"/> Add <input type="checkbox"/> Drop
SSN		Primary physician <input type="checkbox"/> Current patient <input type="checkbox"/> New patient <input type="checkbox"/>		
Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Primary dentist <input type="checkbox"/> Current patient <input type="checkbox"/> New patient <input type="checkbox"/>		

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

Signatures

Member signature	Date
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Spouse must sign if common-law.

Common-law spouse certification: I certify that this person listed above as my spouse and I have an actual and mutual agreement between ourselves to be married; this is a permanent relationship, and our relationship is exclusive, as proven by our cohabitation as spouses; and do hereby hold ourselves out publicly as married. I am aware that this relationship can be dissolved only by legal divorce.

Spouse signature	Date
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If making changes, return completed form no later than Dec. 7, 2024, to:

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