



**Oklahoma State & Education Employees Group Insurance Board
2010 OPTION PERIOD ENROLLMENT/CHANGE FORM
FORMER EMPLOYEES AND SURVIVING DEPENDENTS**

RETURN TO OSEEGIB PO BOX 58010 OKC, OK 73157-8010 POSTMARKED BY DECEMBER 4, 2009

SECTION A: MEMBER INFORMATION (Please Print)

Member Name _____ Member ID/SSN _____

Mailing Address _____ Phone (____) _____

New Address? _____ Alt Phone (____) _____
 Yes No City _____ State _____ Zip Code _____

SECTION B: MEMBER CHANGES TO BE EFFECTIVE 1-1-2010

See back side of form for dependent changes and signatures.

Health Plan No Change Change Health Plan* Drop Health Plan

***To CHANGE your health plan, select from the options below:**

Remember, you and your dependents must all have coverage under the same plan. For example, if you are enrolled in a HealthChoice plan and you are currently insuring dependents, your dependents must also be enrolled in a HealthChoice plan. If you are enrolled in an HMO plan, your dependents must be enrolled in the same HMO.

To elect a MEDICARE plan for yourself or your covered dependents, make a selection from the list below:

HealthChoice Employer PDP Medicare Supp w/Part D	<input type="checkbox"/> High	<input type="checkbox"/> Low	
HealthChoice Medicare Supplement w/out Part D	<input type="checkbox"/> High	<input type="checkbox"/> Low	
UnitedHealthcare Senior Supplement	<input type="checkbox"/> High	<input type="checkbox"/> Low	
CommunityCare Senior MA-PD **	<input type="checkbox"/>		
CommunityCare Senior Alternate MA-PD **	<input type="checkbox"/>		Medicare ID # _____
Generations Healthcare MA-PD **	<input type="checkbox"/>		(as it appears on your Medicare card)
Secure Horizons MA-PD **	<input type="checkbox"/>		

** MA-PD Plan – If you elect an MA-PD plan, you must obtain and complete the MA-PD form as well as complete and return this Option Period form to OSEEGIB.

To elect a PRE-Medicare plan for yourself or your covered dependents, make a selection from the list below:

HealthChoice	<input type="checkbox"/> High	<input type="checkbox"/> Basic	<input type="checkbox"/> USA	<input type="checkbox"/> S-Account
Aetna HMO	<input type="checkbox"/> Standard	<input type="checkbox"/> Alternative		
CommunityCare HMO	<input type="checkbox"/> Standard	<input type="checkbox"/> Alternative		
GlobalHealth HMO	<input type="checkbox"/> Standard	<input type="checkbox"/> Alternative		Member Primary Physician (HMO only)
PacificCare HMO	<input type="checkbox"/> Standard	<input type="checkbox"/> Alternative		<input type="checkbox"/> New Patient <input type="checkbox"/> Current Patient

Dental Plan No Change Change Dental Plan* Drop Dental Plan

***To CHANGE your dental plan, select from the options below:**

<input type="checkbox"/> Assurant Freedom Preferred	<input type="checkbox"/> Delta Dental PPO (POS) _____
<input type="checkbox"/> Assurant Heritage Plus w/SBA (Prepaid)	<input type="checkbox"/> Delta's Choice PPO Member Primary Dentist (Prepaid only)
<input type="checkbox"/> Assurant Heritage Secure (Prepaid)	<input type="checkbox"/> HealthChoice <input type="checkbox"/> New Patient <input type="checkbox"/> Current Patient
<input type="checkbox"/> CIGNA Dental Care Plan (Prepaid)	

Vision Plan No Change Add or Change Vision Plan* DROP Vision Plan

*To ADD or CHANGE your vision plan, select from the options below:

- Humana/CompBenefits VisionCare Plan Superior Vision Plan Vision Service Plan
 Primary Vision Care Services UnitedHealthcare Vision

Member Life Plan No Change Drop all Life Insurance
 Decrease Life Insurance to \$ _____ (Retained in \$5,000 increments)

SECTION C: DEPENDENT CHANGES

SPOUSE

Name: _____ SSN: _____

Pre-Medicare OR Medicare - Medicare ID #: _____

Provide the Medicare ID # as it appears on the Medicare card including any letters.

Date of Birth: _____

Primary Physician: _____ New Patient Current Patient

Primary Dentist: _____ New Patient Current Patient

ADD DROP

N/A Health

N/A Dental

Vision

N/A Dependent Life

Decrease Dependent Life Amount to \$ _____ (Retained in \$500 increments)

CHILD

Name: _____ SSN: _____

Pre-Medicare OR Medicare - Medicare ID #: _____

Provide the Medicare ID # as it appears on the Medicare card including any letters.

Date of Birth: _____ Male Female

Primary Physician: _____ New Patient Current Patient

Primary Dentist: _____ New Patient Current Patient

ADD DROP

N/A Health

N/A Dental

Vision

N/A Dependent Life

Decrease Dependent Life Amount to \$ _____ (Retained in \$500 increments)

SECTION D: IMPORTANT QUESTIONS FOR HEALTHCHOICE MEDICARE ENROLLEES

1. Is your permanent address different than your mailing address? Yes No

If yes, please provide here: _____

2. Do you have additional prescription drug coverage? Yes No

If yes, what is the name of your other coverage? _____ ID# _____

3. Are you a resident in a long-term care facility, such as a nursing home? Yes No

SECTION E: CERTIFICATION SIGNATURES

You must sign the form. Additionally, if you are enrolling in HealthChoice Medicare coverage you must certify the following: I understand that my signature on this application means I have read and understand the information in the "HealthChoice Employer PDP Medicare Information" section of this form.

Member's Signature: _____ **Date:** _____

Spouse must sign if either 1.) S/he is enrolling in or disenrolling from HealthChoice Medicare coverage and/or 2.) S/he is being excluded from health and/or dental coverage.

HealthChoice Medicare: I certify that I understand my signature on this application means I have read and understand the information in the "HealthChoice Employer PDP Medicare Information" section of this form.

Spouse Exclusion Certification: I certify that I am aware **I am being excluded from Health and/or Dental coverage as indicated on this form.** (Required only if dropping spouse while continuing to cover children.)

Spouse's Signature: _____ **Date:** _____

Key Points for Option Period Form

**** General Information for Both Members and Dependents ****

- **HealthChoice Medicare Enrollees** – See additional information on next page.
- **Medicare ID #** - Please provide your Medicare ID# as it appears on your Medicare card, including any letters. You only need to provide your Medicare ID number if you or your dependent are enrolling in any of the HealthChoice Medicare Supplement Plans. If you (or your dependent) are currently enrolled, we already have this number on file.
- **Health (Medicare Advantage/Prescription Drug (MA-PD) Plan)** – If you elect an MA-PD plan, you must contact that plan to obtain an enrollment form. See your Option Period Guide for contact information. Once you complete their enrollment form, it should be returned to the MA-PD plan. You must also complete and return your OSEEGIB *Option Period Enrollment/Change Form* to the address on the front of the form.
- **Split Coverage** – All family members electing coverage must be covered by the same plan, even if there is split coverage between a Medicare plan and a Pre-Medicare plan. For example, if the Medicare individual elects a HealthChoice plan, the Pre-Medicare individual(s) must also elect a HealthChoice plan.
- **HealthChoice USA (Pre-Medicare)** - To be eligible for HealthChoice USA, you must live outside of Oklahoma and Arkansas for more than 90 consecutive days. HealthChoice USA offers a nationwide provider network. The premium for HealthChoice USA is higher than the premium for HealthChoice High. If you return to either of these two states, you must re-enroll in the HealthChoice High Option Plan. The effective date of the change will be the first of the month following your notification to OSEEGIB.
- **HealthChoice S-Account (Pre-Medicare)** - If you enroll in this plan, you must provide proof that you have set up a Health Savings Account at a bank or other financial institution and provide proof of that account to OSEEGIB. This proof must be submitted to OSEEGIB by December 15, 2009. If you do not provide the necessary documentation by this time, you will be removed from the HealthChoice S-Account Plan and enrolled in the HealthChoice Basic Plan for the plan year beginning January 1, 2010.
- **HMO (Pre-Medicare) and/or Prepaid Dental** - If you are switching to a new HMO or Prepaid Dental carrier, you should provide the name of your Primary Care Physician (PCP) or Primary Care Dentist (PCD) and indicate if you are a new or current patient. The HMO/Prepaid Dental Plan will assign you a doctor if you do not name one on this form. If you cover dependents, you should also provide the name of their PCP/PCD in the appropriate location on the back of the form.
- **Confirmation Statement** – If you make any changes to your benefits, a Confirmation Statement will be mailed to you reflecting the benefits you will have on January 1, 2010.

Section A - Member Information

- Please print the member information requested.
- If you currently participate in the HealthChoice health or dental plans, you should provide your OSEEGIB Member ID number. This number can be found on your HealthChoice ID card. You may provide your Social Security Number if you do not participate in the HealthChoice health or dental plan, or you cannot locate your Member ID Number.

Section B – Member Changes

- If you wish to make any changes to your coverage, please mark the appropriate box on the front of the form. Dependent changes will be made on the back page of the form. If changing plans, you must mark the plan you are changing to.
- **CAUTION: If you drop your health or dental coverage and either drop or reduce your life insurance coverage, you will not be able to regain this coverage in the future.**

Section C - Dependent Changes

- **Vision** - Your dependent(s) can only be enrolled in vision coverage if you are enrolled in vision. If you wish to add vision coverage on a dependent, you must mark the “Add” box next to the vision benefit and fill in the dependent’s name.

- **Dropping dependents** - If you want to drop a dependent from health, dental, vision, or life coverage, you must mark the “Drop” box next to each benefit that is to be dropped and fill in the dependent’s name. **CAUTION: If you drop coverage (except vision) on your dependent(s), you will not be able to regain that coverage in the future unless that dependent loses other group coverage.**
- **Dependent Life** – If you are decreasing dependent life, please fill in the dependent’s name and the amount you wish to retain in the space provided. The amount elected must be the same for each dependent child. The amount on your spouse can be different from that of your child(ren).

Section D – Important Questions for HealthChoice Medicare Enrollees

- If you **or your dependent(s)** are enrolling in a HealthChoice Medicare plan, please answer the questions in this section.

Section E - Certification Signatures

- You must sign your form. OSEEGIB cannot process a form without your signature.
- Your spouse must sign the form if:
 - 1.) S/he is enrolling in or disenrolling from HealthChoice Medicare coverage, and/or
 - 2.) S/he is being dropped from health and/or dental and you are continuing to cover dependent children on these benefits.

****HealthChoice Employer PDP Medicare Information****

If you or your dependent(s) are currently a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining HealthChoice Employer PDP High/Low Option Medicare Supplement With Part D Plan, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

If you or your dependent(s) currently have health coverage from an employer or union, joining the HealthChoice Employer PDP High/Low Option Medicare Supplement With Part D Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join HealthChoice Employer PDP. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn’t information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

By completing this Option Period Enrollment/Change Form, I agree to the following:

HealthChoice Employer PDP is a Medicare supplement with prescription drug plan and has a contract with the federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A and B coverage. It is my responsibility to inform HealthChoice of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time – if I am currently in a Medicare Prescription Drug Plan, my enrollment in HealthChoice will end that enrollment. Enrollment in this Plan is generally for the entire year. Once I enroll, I may only leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period, unless I qualify for certain special circumstances.

HealthChoice serves the entire United States. If I move out of the United States, I need to notify HealthChoice so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use HealthChoice network pharmacies. Once I am a member of HealthChoice, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from HealthChoice when I get it to know the rules I must follow to get coverage.

I understand that if I leave this Plan and don’t have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare’s), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage if I re-enroll in the future.

Release of Information:

By joining this Medicare supplement prescription drug plan, I acknowledge that HealthChoice will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that HealthChoice will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. The information on this Option Period Enrollment/Change Form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under state law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request by HealthChoice or Medicare.

****Privacy Notice******THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

OSEEGIB is a State of Oklahoma governmental agency that is created and governed by Oklahoma law for the purpose of administering health, life, disability, and dental benefits to state, local government, and education employees, and other groups designated by statute, including each of the preceding groups' respective retirees. Oklahoma privacy laws and the federal Health Insurance Portability and Accountability Act (HIPAA) govern privacy matters between OSEEGIB and its participants concerning the privacy of identifiable health information. Information contained in an OSEEGIB member's file is confidential by law and we at OSEEGIB are committed to protecting this information.

This notice describes and gives you examples of the permitted ways your health information may be used and disclosed.

OSEEGIB uses and discloses your protected health information for your treatment, payment for services, and OSEEGIB business operations in the administration of health plans. The health claims you submit, or health claims submitted by providers for your treatment, contain protected health information and are processed for payment and data collection by claims administrators according to Oklahoma law and contractual terms of confidentiality with OSEEGIB. Your health information is used and disclosed by OSEEGIB employees and other entities under contract with OSEEGIB according to the 'minimum necessary' standard. OSEEGIB or its claims administrators may use and disclose health information, to determine medical necessity for pre-certification of hospital and medical benefits, case management, approval for supplemental life insurance, grievance matters, premium rate setting, required disease management programs, law enforcement, public health threats, workers' compensation/disability, national security, and as required by law. OSEEGIB will ask for your written permission before it uses or discloses your health information for purposes that are not described in this Notice.

You have the right to: a) inspect and copy your health information (generally EOBs) with the exception of psychotherapy notes and / or information that requires a court order; b) amend and restrict the health information that OSEEGIB discloses about you; however, OSEEGIB is not required to agree to a requested restriction; c) request your communications remain confidential with OSEEGIB; d) receive a copy of this Notice; e) file a complaint if you believe OSEEGIB has improperly used or disclosed your information; f) request a listing of disclosures, except for treatment, payment, business operations, and per your Authorization after April 14, 2003; and, g) receive a paper copy of this Notice upon request if you have received this Notice electronically.

OSEEGIB reserves the right to change the terms of this Privacy Notice and will provide all interested persons a revised notice either by U.S. Postal Service delivered to the individual's mailing address on file with OSEEGIB or electronic communication by posting the revised Privacy Notice on the OSEEGIB website at www.healthchoiceok.com and www.sib.ok.gov

If you believe your privacy rights have been violated, call or send a written complaint to the OSEEGIB HIPAA Information Officer at 3545 NW 58th, Suite 110, Oklahoma City, Oklahoma 73112, 405-717-8701, Toll-free 1-800-752-9475, TDD 405-949-2281, Toll-free TDD 1-866-447-0436, the Secretary of the U. S. Department of Health and Human Services (HHS) at the Office of Civil Rights, 1301 Young Street, Suite 1169, Dallas, Texas 75202 1-214-767-4056, or submit an electronic complaint according to directions located on the HHS Office of Civil Rights website. Complaints to HHS must be filed within 180 days after the date on which you became aware, or should have been aware, of the violation. No retaliation is allowed against the individual filing a complaint.

Revised Notice 8/5/05