Enrollment Form
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Member SSN

PLEASE CHECK WITH YOUR EMPLOYERS BENEFIT COORDINATOR TO SEE WHICH OF THE BENEFIT OPTIONS LISTED ON THIS FORM ARE AVAILABLE TO YOU, AS EACH EMPLOYER GROUP MAY OFFER DIFFERENT BENEFIT OPTIONS.

Member Information (Details required even if waiving medical coverage.)

Last Name **Gender** ◯ Male ◯ Female

First Name **Middle Initial**

Date of Birth / / **Marital Status** ◯ Single ◯ Married/Legal Spouse

Mailing Address

City, State & Zip

Email Address

Phone (home or cell) - - **Work Phone** - -

Health Plan Options **Medical/Rx** ◯ Yes ◯ No **Dental** ◯ Yes ◯ No **Vision** ◯ Yes ◯ No

Voluntary Dental w/ Orthodontic Coverage ◯ Yes ◯ No *(This is a separate, individual dental plan through MetLife.)*

Life Insurance Options **Group Life** ◯ **Additional Life** ◯ Amount* (in thousands) $ **Accidental Death & Dismemberment Rider** ◯

**You must complete the attached Additional Life Coverage worksheet to help you calculate how much Additional Life insurance you can get. Then, you can fill in the boxes above with the amount you would like to request (not to exceed the amount calculated in Step 2 of the worksheet)*

Spouse Information (Details required even if waiving coverage, due to being covered under group life coverage)

Last Name **Gender** ◯ Male ◯ Female

First Name **Middle Initial**

Date of Birth / / **SSN**

Health Plan Options **Medical/Rx** ◯ Yes ◯ No **Dental** ◯ Yes ◯ No **Vision** ◯ Yes ◯ No

Voluntary Dental w/ Orthodontic Coverage ◯ Yes ◯ No *This is a separate, individual dental plan through MetLife.The Member must also enroll in this coverage in order to enroll a dependent.*

Life Insurance Option **Additional Life** ◯ Amount (in thousands) $ *Complete the attached Additional Life Coverage worksheet to help you calculate how much additional life insurance your spouse can have.*

Life Insurance Beneficiary *You can select multiple primary or secondary beneficiaries for your life insurance. You can divide the benefit any way you want. We suggest you select at least 1 primary, and 1 secondary beneficiary. Additional beneficiaries can be selected later on this form. You can change your beneficiary designations at any time.*

Do you want your spouse to be a beneficiary of your life insurance? ◯ Yes ◯ No / ◯ Primary or ◯ Secondary % of Benefit

Authorization to release Protected Health Information (PHI)

Do you authorize the Plan Administrative Office to speak with your spouse on your behalf? ◯ Yes ◯ No

Please select the type of information we can release to your spouse: ◯ Health Plan Information ◯ Premium Information ◯ Authorization Information ◯ Claims Information

This Section to be completed by Entity Benefit Coordinator Only

Entity Name

Employment Date / / **Job Status** ◯ Full-time ◯ Part-time

Department

Requested Effective Date / / **Gross Annual Pay** $

Purpose of this form ◯ Enroll New Employee ◯ Change Employee Coverage ◯ Add New Spouse/Dependent ◯ Change Spouse/Dependent Coverage

If the employee is requesting a change in coverage and this is not the Plan's Annual Renewal Period, then please attach the appropriate documentation required as proof of a qualifying event. Refer to the Plan's Benefit Coordinator Handbook or the Benefit Book for a list of qualifying events and documentation. To update Addresses, Life Beneficiaries or PHI Authorizations without a coverage change, please use the appropriate form instead of this form. All forms can be found on the Plan's website at **www.opehw1.com.**

PROMPTLY SEND ALL PAGES OF THIS FORM TO THE PLAN ADMINISTRATOR

OPEH&W HealthPlan

Enrollment Form

Member SSN ☐☐☐☐☐☐☐☐☐

Dependent Children Information (Details required even if waiving coverage, due to being covered under group life)

Last Name ________ **Gender** ◯ Male ◯ Female

First Name ________ **Middle Initial** ☐

Date of Birth __ / __ / ____ **SSN** ________ ◯ Disabled Dependent

Relationship ________

Health Plan Options **Medical/Rx** ◯Yes ◯No **Dental** ◯Yes ◯No **Vision** ◯Yes ◯No

Voluntary Dental w/ Orthodontic Coverage ◯ Yes ◯ No *This is a separate, individual dental plan through MetLife. The Member must also enroll in this coverage in order to enroll a dependent.*

Life Insurance Beneficiary

Do you want this child to be a beneficiary of your life insurance? ◯ Yes ◯ No / ◯ Primary or ◯ Secondary ☐☐☐ % of Benefit

Authorization to release Protected Health Information (PHI)

Do you authorize the Plan Administrative Office to speak with this child on your behalf? ◯ Yes ◯ No

Please select the type of information we can release to this child: ◯ Health Plan Information ◯ Premium Information ◯ Authorization Information ◯ Claims Information

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Last Name ________ **Gender** ◯ Male ◯ Female

First Name ________ **Middle Initial** ☐

Date of Birth __ / __ / ____ **SSN** ________ ◯ Disabled Dependent

Relationship ________

Health Plan Options **Medical/Rx** ◯Yes ◯No **Dental** ◯Yes ◯No **Vision** ◯Yes ◯No

Voluntary Dental w/ Orthodontic Coverage ◯ Yes ◯ No *This is a separate, individual dental plan through MetLife. The Member must also enroll in this coverage in order to enroll a dependent.*

Life Insurance Beneficiary

Do you want this child to be a beneficiary of your life insurance? ◯ Yes ◯ No / ◯ Primary or ◯ Secondary ☐☐☐ % of Benefit

Authorization to release Protected Health Information (PHI)

Do you authorize the Plan Administrative Office to speak with this child on your behalf? ◯ Yes ◯ No

Please select the type of information we can release to this child: ◯ Health Plan Information ◯ Premium Information ◯ Authorization Information ◯ Claims Information

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Last Name ________ **Gender** ◯ Male ◯ Female

First Name ________ **Middle Initial** ☐

Date of Birth __ / __ / ____ **SSN** ________ ◯ Disabled Dependent

Relationship ________

Health Plan Options **Medical/Rx** ◯Yes ◯No **Dental** ◯Yes ◯No **Vision** ◯Yes ◯No

Voluntary Dental w/ Orthodontic Coverage ◯ Yes ◯ No *This is a separate, individual dental plan through MetLife. The Member must also enroll in this coverage in order to enroll a dependent.*

Life Insurance Beneficiary

Do you want this child to be a beneficiary of your life insurance? ◯ Yes ◯ No / ◯ Primary or ◯ Secondary ☐☐☐ % of Benefit

Authorization to release Protected Health Information (PHI)

Do you authorize the Plan Administrative Office to speak with this child on your behalf? ◯ Yes ◯ No

Please select the type of information we can release to this child: ◯ Health Plan Information ◯ Premium Information ◯ Authorization Information ◯ Claims Information

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Additional Life Insurance Option for Dependent Children

Additional Life Coverage for Dependent Children is available to you if you have selected Additional Life Coverage for yourself **and** if your Dependent Children are under age 21 and unmarried, or age 21 and over if unmarried and a full-time student. Two coverage amounts are available. One premium covers all your eligible children. Select from the two amounts listed to the right:

◯ $10K additional coverage for all eligible children (one $2 premium/mo.)

◯ $20K additional coverage for all eligible children (one $4 premium/mo.)

◯ Decline coverage, or children not eligible, or not available to my group

If you require additional dependent child slots, you may make as many copies of this page as necessary

Beneficiary Designations and/or PHI Authorizations

(For use when designating someone other than your Spouse or Dependent Children previously listed on this form)

Last Name **Gender** ○ Male ○ Female

First Name **Middle Initial**

Date of Birth / / **SSN**

Mailing Address

City, State & Zip

Primary Phone - -

Relationship

Do you want this person to be a beneficiary of your life insurance? ○ Yes ○ No ○ Primary ○ Secondary % of Benefit

Protected Health Information (PHI) Release Authorization

Do you authorize the Plan Administrative Office to speak with this person on your behalf, and about you and your coverage through this health plan? ○ Yes ○ No

Please select the type of information we can release to this beneficiary: ○ Health Plan Information ○ Premium Information ○ Authorization Information ○ Claims Information

Last Name **Gender** ○ Male ○ Female

First Name **Middle Initial**

Date of Birth / / **SSN**

Mailing Address

City, State & Zip

Primary Phone - -

Relationship

Do you want this person to be a beneficiary of your life insurance? ○ Yes ○ No ○ Primary ○ Secondary % of Benefit

Protected Health Information (PHI) Release Authorization

Do you authorize the Plan Administrative Office to speak with this person on your behalf, and about you and your coverage through this health plan? ○ Yes ○ No

Please select the type of information we can release to this beneficiary: ○ Health Plan Information ○ Premium Information ○ Authorization Information ○ Claims Information

Last Name **Gender** ○ Male ○ Female

First Name **Middle Initial**

Date of Birth / / **SSN**

Mailing Address

City, State & Zip

Primary Phone - -

Relationship

Do you want this person to be a beneficiary of your life insurance? ○ Yes ○ No ○ Primary ○ Secondary % of Benefit

Protected Health Information (PHI) Release Authorization

Do you authorize the Plan Administrative Office to speak with this person on your behalf, and about you and your coverage through this health plan? ○ Yes ○ No

Please select the type of information we can release to this beneficiary: ○ Health Plan Information ○ Premium Information ○ Authorization Information ○ Claims Information

If you require additional space, you may make as many copies of this page as necessary.

Waiver of Benefits & Notice of Special Enrollment Rules

Only complete this section if you are waiving Health coverage (medical & prescription) for yourself, your spouse, or dependent children.

I hereby elect to waive participation in the Oklahoma Public Employees Health & Welfare Plan for Medical & Rx Benefits for the following:

◯ Employee	◯ Is Covered Under Other Health Coverage	◯ Other: _____
◯ Spouse	◯ Is Covered Under Other Health Coverage	◯ Other: _____
◯ Dependent Children	◯ Is Covered Under Other Health Coverage	◯ Other: _____

You should apply for coverage for yourself and/or your dependents within 31 days of being first eligible to do so. If you do not, then you might have to wait until the Plan's next Renewal Period to enroll.

However, if you are declining enrollment for yourself or your spouse or dependent children because you and/or they are covered under another group health plan or have other health insurance coverage, you may be able to enroll yourself and/or your dependents in the Plan in the future if you and/or they should experience a loss of other coverage. The Plan includes Special Enrollment Periods during which individuals who previously declined coverage are allowed to enroll without having to wait until the next Renewal Period. A Special Enrollment Period can occur if a person with other health coverage loses that coverage or if a person becomes a Dependent through marriage, birth, adoption or Placement for Adoption.

You may be eligible to enroll during a Special Enrollment Period if you lose your other health insurance coverage and you stated in writing that other such coverage was the reason for declining enrollment and one of the following events has occurred: (i) the other coverage was terminated as a result of loss of eligibility for that coverage; (ii) the other coverage was COBRA continuation coverage under another plan and COBRA continuation under that other plan has been exhausted; or (iii) the employer contributions towards the other coverage have been terminated. You may also be able to enroll if you acquire a new Eligible Dependent as a result of marriage, birth of a child, or adoption or placement for the purpose of adopting of a child under the age of 18. You must apply for coverage for yourself or your dependents within 31 days after the date of one of the special enrollment events described above. If you do not, then you must wait until the Plan's next Annual Renewal Period to enroll. The Renewal Period is held each year from May 1st to May 31st and requested changes will take effect on July 1st (the start of the new Plan Year).

Personal Certification & Acknowledgements

I hereby enroll for benefits which I am presently eligible or for which I may become eligible under my employer's group application. I authorize deductions for this coverage from my earnings if any such deductions are required. I reserve the right to revoke this deduction authorization at any time upon written notice.

I hereby certify that I have completed this Enrollment Form and that the above statements are true and complete. I understand that false or deceptive statements made on this Enrollment Form or in filing a claim for benefits under the Plan will result in termination of coverage and possible prosecution for fraudulent misrepresentation.

Employee Signature _____ **Date** _____

Additional Life Coverage

YOUR SSN

Additional Life Coverage is available to you. This is Life Coverage which you, the employee, pay for. It is different than the Life Coverage which your Employer pays for. Use this step-by-step guide to determine how much Additional Life Coverage you are able to get and how much it will cost. Read the instructions for each step carefully. You might want to use a pencil to start with, and overwrite in ink after you have made a final decision. You may also need a calculator.

Additional Life Coverage for **You**

Step 1 — Your Annual Pay

$ ___k

What is your annual pay? This is how much you earn each year before taxes rounded down to the nearest thousand. If needed, you can ask your Employer's Benefit Coordinator for this information. Example: for $26,874 enter 26.

Step 2 — Amount of Additional Life Coverage You Can Get

$ ___k

How much Additional Life Coverage can you get? Multiply the amount in Step1 by 5. This is the most Additional Life Coverage you are able to get (cannot exceed $500,000). The Life Coverage which your Employer pays for does not count towards this amount. Example: for 26 x 5 enter 130.

Step 3 — Your Age Rated Cost

$ __.__

Based on your age, what is the cost for each $1,000 of coverage? Find your age based cost per $1,000 of coverage from the Rate Table in Step 14 and write it here. Example: If you are 51 years old, you would enter 0.39.

Step 4 — Amount of Additional Life Coverage You Want

$ ___k

How much Additional Life Coverage do you want? It starts at $20,000, after which it is available in $5,000 units; however, if you intend to also enroll a spouse for Additional Life Coverage you must begin at $40,000 and increase in $5,000 units thereafter. It cannot exceed the amount listed in Step 2.

If this is the 1st time you have been offered Additional Life Coverage through the Health Plan, you can select up to $150,000 (or 5 times your annual pay, whichever is less) of Additional Life Coverage without having to answer any questions about your health. If you want more than $150,000 you can select Additional Life Coverage up to the number listed in Step 2, and complete a simple form about your health (ask your Employer's Benefit Coordinator for the Health Questionnaire).

If you already have Additional Life Coverage through the Health Plan and would like to increase your coverage; if you did not take out all of the amount from Step 2 then the next $5,000 of coverage is available to you without having to answer any questions about your health. If you increase your Additional Life Coverage Amount by more than $5,000 then you will need to complete a simple form about your health (ask your Employer's Benefit Coordinator for the Health Questionnaire).

If in the past you have been offered Additional Life Coverage through the Health Plan and chose not to enroll, then you may select any coverage amount up to the amount from Step 2. You will need to complete a simple form about your health (ask your Employer's Benefit Coordinator for the Health Questionnaire).

Step 5 — Monthly Cost of Your Additional Life Coverage

$ ___.__

Multiply the amount you listed in Step 4 (Amount of Additional Life Coverage you want) by Step 3 (Your age rated cost). Example: You're 51 years old and want $95,000 of Additional Life Coverage, multiply 95 by 0.39 (95 x 0.39).

Step 6 — Accidental Death & Dismemberment Coverage

$ ___.__

This is an additional benefit you can purchase that pays twice the amount of your selected coverage if you are killed in an accident. It also pays a benefit if you should suffer an injury in an accident, such as loss of a limb, loss of the use of a limb or loss of sight and/or hearing. It costs just $0.03 per $1,000 of coverage you have selected, regardless of your age. If you select this option it must be taken out on the full amount of additional life coverage you have selected. This coverage is only available to employees (not a spouse or dependent).

Multiply the amount you listed in Step 4 (Amount of Additional Life Coverage you want) by 0.03 and write it here. Example: You want to add Accidental Death & Dismemberment Coverage to $95,000 of Additional Life Coverage, multiply 95 by 0.03 (95 x 0.03).

Step 7 — Total Monthly Cost of Additional Life Coverage for You

Add together Step 5 + Step 6

$ ___.__

Continued on next page

Additional Life Coverage for your **Spouse**

Step 8 — **Most Additional Life Coverage Your Spouse Can Get** $ ___k

Additional Life Coverage for your Spouse starts at $20,000, after which it is available in $5,000 units. Spouse Additional Life Coverage is only available if you have selected Additional Life Coverage for yourself, and cannot be more than half of the amount of Additional Life Coverage you have selected for yourself from Step 4 rounded down to the nearest $5,000. Example: If Step 4 was $125,000, the most Spouse coverage available would be $60,000.

Step 9 — **Your Spouse's Age Rated Cost** $ ___.___

Based on your Spouse's age, what is the cost for each $1,000 of coverage? Find your Spouse's age based cost per $1,000 of coverage from the Rate Table in Step 14 and write it here. Example: If your Spouse is 51 years old, you would enter 0.39.

Step 10 — **How Much Additional Life Coverage Do You Want For Your Spouse** $ ___k

If this is the 1st time you have been offered Additional Life Coverage through the Health Plan, you can select up to $50,000 of Additional Life Coverage for your Spouse without having to answer any questions about their health. If you want more than $50,000 you can select Additional Life Coverage up to the number listed in Step 8, and complete a simple form about their health (ask your Employer's Benefit Coordinator for the Health Questionnaire).

If in the past you have been offered Additional Life Coverage through the Health Plan and chose not to enroll Yourself or Spouse, or if in the past you enrolled but did not enroll your Spouse, then, you may select any coverage amount up to the amount listed in Step 8, and your Spouse will need to complete a simple form about their health (ask your Employer's Benefit Coordinator for the Health Questionnaire).

Step 11 — **Monthly Cost of Additional Life Coverage for your Spouse** $ ___.___

Multiply the amount you listed in Step 10 by Step 9. Example: Your Spouse is 46 years old and you want $50,000 of Additional Life Coverage for them, multiply 50 by 0.23 (50 x 0.23).

Additional Life Coverage for your **Dependent Children**

Step 12 — **Monthly Cost of Additional Life Coverage for your Dependent Children** $ ___.___

Additional Life Coverage for Dependent Children is available to you if you have selected Additional Life Coverage for yourself and if your Dependent Children are under age 21 and unmarried, or age 21 and over if unmarried and a full-time student. Two coverage amounts are available: $10,000 of coverage for $2 per month or $20,000 of coverage for $4 per month. One premium covers all your Dependent Children. To select Additional Life Coverage for your Dependent Children, simply write in the monthly premium amount, or enter 0 if you do not want any. If this is not the first time you have been offered Additional Life Coverage for your Dependent Children, then a simple form about their health will be required (ask your Employer's Benefit coordinator for the Health Questionnaire). Example: You have 3 children that are unmarried and under age 21 and you want $20,000 of Additional Life Coverage on each child, you would enter $4.

Step 13 — Your **Total Monthly Cost** for Additional Life Coverage $ ___.___

Add together Step 7 + Step 11 + Step 12. This is the amount which will come out of your paycheck each month.

Step 14 — **Rate Table – Age based cost per $1,000 of Coverage for use in Steps 3 & 9**

Age 34 & Under $0.07	Age 35 - 39 $0.10	Age 40 - 44 $0.14	Age 45 - 49 $0.23	Age 50 – 54 $0.39
Age 55 – 59 $0.64	Age 60 - 64 $0.74	Age 65 - 69 $1.21	Age 70 - 74 $2.05	Age 75 & Over $3.18

Step 15 — Your **Signature**

Print Name Here

Sign Name Here

Your SSN _____

Date __/__/20__

Return This Completed Form To Your Employer's Benefit Coordinator