



Member SSN input boxes

Beneficiary Designations and/or PHI Authorizations

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

Form fields for beneficiary 1: Last Name, First Name, Date of Birth, Mailing Address, City, State & Zip, Primary Phone, Relationship, Gender, Middle Initial, SSN, % of Benefit

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

Form fields for beneficiary 2: Last Name, First Name, Date of Birth, Mailing Address, City, State & Zip, Primary Phone, Relationship, Gender, Middle Initial, SSN, % of Benefit

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

Form fields for beneficiary 3: Last Name, First Name, Date of Birth, Mailing Address, City, State & Zip, Primary Phone, Relationship, Gender, Middle Initial, SSN, % of Benefit

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



SSN input boxes

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, Spouse, Dependent Children, Is Covered Under Other Health Coverage, Other: (radio button options)

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.

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.

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

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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	\$	<input type="text"/> <input type="text"/> <input type="text"/> k
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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	\$	<input type="text"/> <input type="text"/> <input type="text"/> k
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How much Additional Life Coverage can you get? Multiply the amount in **Step 1** 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	\$	<input type="text"/> <input type="text"/> <input type="text"/>
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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	\$	<input type="text"/> <input type="text"/> <input type="text"/> k
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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	\$	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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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	\$	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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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	\$	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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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

\$

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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

\$

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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

\$

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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

\$

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Additional Life Coverage for eligible Dependent Children is available to you if you have selected Additional Life Coverage for yourself. 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 eligible Dependent Children. To select Additional Life Coverage for your eligible 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 eligible 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 and you want \$20,000 of Additional Life Coverage on each child, you would enter \$4 for the monthly cost.

Step
13

Your Total Monthly Cost for Additional Life Coverage

\$

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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

Your
SSN

Sign Name Here

Date

/ / 20

Return This Completed Form To Your Employer's Benefit Coordinator