



Office of Management and Enterprise Services Employees Group Insurance Division
2019 OPTION PERIOD ENROLLMENT/CHANGE FORM
CURRENT EMPLOYEE

THIS FORM MUST BE RETURNED TO YOUR INSURANCE COORDINATOR

SECTION A: EMPLOYEE INFORMATION (Please Print)

Group ID# 724014 Division ID# 0698 Group Name Liberty-Mounds Public School

Member Name _____ SSN or Member ID# _____
 First Name MI Last Name

Gender Male Female _____ / ____ / ____ Married Single
 Birth Date

Mailing Address _____ Phone _____ - _____ - _____
 New Address
 City State ZIP Code Alt Phone _____ - _____ - _____

Email Address _____

SECTION B: ALL CHANGES ARE EFFECTIVE JAN. 1, 2019

See back of form for required signatures and enrollment or change to dependent coverage.

Health Plan

Check a box to ADD or CHANGE plans:

- No Change
 Drop All Health

- Aetna HMO
 BlueLincs HMO
 CommunityCare HMO
 GlobalHealth HMO
 HealthChoice Basic* or Basic Alternative (refer to Option Period materials)
 HealthChoice High* or High Alternative (refer to Option Period materials)
*Requires completion of tobacco-free attestation or reasonable alternative.
 HealthChoice High Deductible Health Plan (HDHP)

Employee Primary Physician (HMO Plans Only) _____ New Patient Current Patient

Dental Plan

Check a box to ADD or CHANGE plans:

- No Change
 Drop All Dental

- Cigna Dental Care Plan (Prepaid)
 Delta Dental PPO
 Delta Dental PPO – Choice
 HealthChoice Dental Plan
 MetLife High Classic MAC
 MetLife Low Classic MAC
 Sun Life Preferred Active PPO

Employee Primary Dentist (Prepaid Plans Only) _____ New Patient Current Patient

Vision Plan

Check a box to ADD or CHANGE plans:

- No Change
 Drop All Vision

- Primary Vision Care Services (PVCS)
 Superior Vision
 Vision Care Direct
 VSP (Vison Service Plan)

Employee Life Plan

Employee life CANNOT be added or increased using this form. A separate Life Insurance Application must be completed and approved to add or increase life insurance coverage.

No Change Drop All Life Insurance

Decrease Total Life Insurance to: \$ _____
 (Keep employee life in \$20,000 units)

*I have added or made changes on the back of this form for my dependents.

Dependent Life Plan (Employee Life Required)

- No Change
 Drop Dependent Life
 Add or Increase to Premier Option
 Add or Increase/Decrease to Standard Option
 Add or Decrease to Low Option

FOR IC USE ONLY

FOR EGID USE ONLY

SECTION C: DEPENDENT COVERAGE

SPOUSE*

Add Drop

<input type="checkbox"/>	<input type="checkbox"/>	Health	Name _____	SSN _____
<input type="checkbox"/>	<input type="checkbox"/>	Dental	Date of Birth _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/>	<input type="checkbox"/>	Vision	Primary Physician _____	<input type="checkbox"/> New Patient <input type="checkbox"/> Current Patient
<input type="checkbox"/>	<input type="checkbox"/>	Dependent Life	Primary Dentist _____	<input type="checkbox"/> New Patient <input type="checkbox"/> Current Patient

*Does your spouse currently have coverage through EGID? Yes No (If yes, list name and SSN above.)

CHILD

Add Drop

<input type="checkbox"/>	<input type="checkbox"/>	Health	Name _____	SSN _____
<input type="checkbox"/>	<input type="checkbox"/>	Dental	Date of Birth _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/>	<input type="checkbox"/>	Vision	Primary Physician _____	<input type="checkbox"/> New Patient <input type="checkbox"/> Current Patient
<input type="checkbox"/>	<input type="checkbox"/>	Dependent Life	Primary Dentist _____	<input type="checkbox"/> New Patient <input type="checkbox"/> Current Patient

CHILD

Add Drop

<input type="checkbox"/>	<input type="checkbox"/>	Health	Name _____	SSN _____
<input type="checkbox"/>	<input type="checkbox"/>	Dental	Date of Birth _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/>	<input type="checkbox"/>	Vision	Primary Physician _____	<input type="checkbox"/> New Patient <input type="checkbox"/> Current Patient
<input type="checkbox"/>	<input type="checkbox"/>	Dependent Life	Primary Dentist _____	<input type="checkbox"/> New Patient <input type="checkbox"/> Current Patient

CHILD

Add Drop

<input type="checkbox"/>	<input type="checkbox"/>	Health	Name _____	SSN _____
<input type="checkbox"/>	<input type="checkbox"/>	Dental	Date of Birth _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/>	<input type="checkbox"/>	Vision	Primary Physician _____	<input type="checkbox"/> New Patient <input type="checkbox"/> Current Patient
<input type="checkbox"/>	<input type="checkbox"/>	Dependent Life	Primary Dentist _____	<input type="checkbox"/> New Patient <input type="checkbox"/> Current Patient

PLEASE USE THE DEPENDENT ATTACHMENT FORM TO ADD MORE DEPENDENTS.
(This form is available from your insurance coordinator.)

SECTION D: CERTIFICATION SIGNATURES

Employee Name (Print) _____

Employee Signature _____ **Date** _____

SPOUSE MUST SIGN IF COMMON-LAW OR EXCLUDED FROM HEALTH AND/OR DENTAL COVERAGE.

COMMON-LAW SPOUSE CERTIFICATION: I certify the person listed as my spouse and I have an actual and mutual agreement between ourselves to be married; that 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 EXCLUSION CERTIFICATION (required only if children are covered and spouse is not): I certify that I am aware **I am being excluded from health and/or dental coverage as indicated on this form.** I am also aware that an employee who elects to cover all eligible dependent children and NOT their spouse will not have the opportunity to enroll their spouse until either the next annual Option Period or a change of status event occurs.

Spouse Signature _____ **Date** _____