

DEPENDENT INFORMATION

Keep Drop
SPOUSE Health Medicare ID# (Required if Medicare eligible): _____
 Dental Name: _____ SSN: _____
 Vision Date of Birth: _____
 Dep Life I elect to keep \$ _____ (in \$500 increments) of Dependent Life Insurance

Does your Spouse currently have health, dental, or vision coverage through OSEEGIB? Yes No (If yes, list Name and SSN above)

Keep Drop
CHILD Health Medicare ID# (Required if Medicare eligible): _____
 Dental Name: _____ SSN: _____
 Vision Date of Birth: _____ Male Female
 Dep Life I elect to keep \$ _____ (in \$500 increments) of Dependent Life Insurance

Keep Drop
CHILD Health Medicare ID# (Required if Medicare eligible): _____
 Dental Name: _____ SSN: _____
 Vision Date of Birth: _____ Male Female
 Dep Life I elect to keep \$ _____ (in \$500 increments) of Dependent Life Insurance

IF YOU OR YOUR DEPENDENTS ARE ON HEALTHCHOICE EMPLOYER PDP HIGH/LOW OPTION MEDICARE SUPPLEMENT WITH PART D, PLEASE READ THE FOLLOWING.

By completing this enrollment application, I agree to the following:

HealthChoice Employer PDP is a Medicare Supplement With Part D (prescription drug) Plan and is in addition to my coverage under Medicare Parts A and/or B; therefore, I will need to keep my Parts A and/or B. 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 enrolled in one Medicare Part D 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. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to HealthChoice or by calling toll-free 1-800-Medicare (24 hours a day/7 days a week). TDD users should call toll-free 1-877-486-2048.

HealthChoice serves the entire United States. If I move out of the United States, I need to notify HealthChoice so I can be disenrolled from the Plan. 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 receive it to know which rules I must follow in order to receive coverage with this Medicare Supplement With Part D Plan.

I understand that if I leave this Plan and do not have or obtain other Medicare prescription drug coverage or creditable 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 in the future.

Release of Information:

By joining the HealthChoice Employer PDP High/Low Option Medicare Supplement With Part D 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 date, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. The information I provided on this Enrollment 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 on this application means that I have read and understand the contents of this application. The information on this enrollment 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.

CERTIFICATION SIGNATURES

I authorize the Board to deduct the amount of my premiums from my retirement check according to Board Rule 360:10-3-3-5. You must verify with your retirement system to insure your retirement check will cover your premiums.

I request that the Board direct bill me for my monthly premiums at the mailing address above.

Spouse must sign 1.) if he/she is enrolling in Medicare coverage and/or 2.) if he/she is being excluded from health/dental and/or 3.) if he/she is a common-law spouse.

Spouse Exclusion Certification: 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 I cannot be added to coverage at a later date except for within 30 days of loss of other group coverage. (Needed only if children are covered and spouse is not.)

Common-Law Spouse Certification: I certify that the person listed as my spouse and I have an actual and mutual agreement between ourselves to be husband and wife; that this is a permanent relationship; and that our relationship is exclusive, as proven by our cohabitation as man and wife; and do hereby hold ourselves out publicly as husband and wife. I am aware that this relationship can only be dissolved by legal divorce.

Spouse’s Signature: _____ Date: _____

I understand that any coverage (except vision) not kept cannot be added at a later date.

Member Signature: _____ Date: _____

**IMPORTANT-STATUTES ALLOW ELECTION OF INSURANCE
WITHIN 30 DAYS OF THE RETIREMENT, VESTING, OR NON-VESTING DATE**

Retirement information can be found at www.healthchoicework.com

You may carry health, dental, vision, and life insurance on yourself and your dependents.

The health, dental, and life coverage that you take into retirement/vest is the only coverage you may have through your retirement years. If you do not retain coverage **now**, you may not add it later. **Cancellation** of any basic insurance coverage after your termination of employment prevents you from adding that coverage at a later date. **Plan changes** can be made at Option Period.

If you are insuring one dependent, **you must insure all eligible dependents (for any given coverage) unless covered by other group insurance, Indian or military benefits.** Children with Indian or military benefits or other group insurance may be required to show proof of coverage.

Dependents may only be added after retirement within 30 days of one of the following occurs:

1. Birth, adoption or guardianship.
2. Marriage.
3. Loss of other group insurance.

*** DEFER** If you have a spouse who has separate coverage through OSEEGIB at the time of your termination of employment, you may transfer your individual health, dental, or vision coverage as a retiree/vest to dependent coverage through your spouse. The employed spouse must contact their employer to add dependent coverage. You must make the election to transfer coverage within 30 days of your termination of employment. Any 30-day break in coverage will void your eligibility to retain coverage in the future. Life insurance must be carried as a primary retiree/vested member. You can only defer your health, dental, or vision benefits. When you are ready to return to a member status, you must complete this form and mark "yes" to cancel your previous deferment.

THINGS TO CONSIDER AS A RETIREE WHEN BECOMING MEDICARE ELIGIBLE

IMPORTANT: *If you are under age 65 and eligible for Medicare, you must notify OSEEGIB and provide your Medicare ID# as it appears on your Medicare card. Medicare Supplement coverage will become effective as of the date you become eligible for Medicare, or the 1st of the month following notification of your Medicare eligibility, whichever is later.*

At Medicare eligibility, you will be enrolled in the Medicare Supplement of your plan at that time. If you are on HealthChoice Employer PDP Medicare Supplement, you will be enrolled in the Medicare Supplement High Option with Part D Plan. **If you are on an HMO, you may enroll in their Medicare Supplement or Medicare Advantage Prescription Drug (MAPD) plan. You must contact your HMO for more information on enrollment into an MA-PD.**

Medicare eligible members must have Medicare Part A and Medicare Part B. All Medicare Supplement plans and MA-PD plans offered through OSEEGIB require you to have both.

If you or one of your dependents will soon become Medicare eligible, please pay close attention to the deadlines for enrollment into a Medicare supplement or Medicare Advantage plan with Part D benefits. Enrollments that are not received within the timeframe established by CMS will delay your enrollment into a Medicare Part D plan.

CMS does not allow members to be retroactively enrolled into any Part D participating plan. Because of this regulation, when enrollment forms are received after the requested effective date, OSEEGIB must place members into the HealthChoice Employer PDP Medicare Supplement Plan Without Part D until the 1st of the month following the receipt of your enrollment form. Be aware that this alternate plan without Part D has a higher premium than the plan with Part D benefits, but does have Creditable Coverage.

IMPORTANT INFORMATION FOR MEDICARE MEMBERS

If you or your dependent(s) are currently a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have a prescription drug benefit from your Medicare Advantage plan that will meet your needs. By joining HealthChoice Employer PDP High/Low Option Medicare Supplement With Part D, 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. Joining HealthChoice Employer PDP High Option Medicare Supplement With Part D may change how the benefits of your current coverage are administered. Read the information your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no contact information available, contact your benefits administrator or the office that answers questions about your coverage.

(Continued on next page.)

For information concerning HMOs, MA-PDs, Dental, or Vision plans, contact their customer service numbers.

For information on HealthChoice or the HealthChoice Medicare Supplement Plans, contact:

Oklahoma State and Education Employees Group Insurance Board
3545 NW 58th, Suite 110, Oklahoma City, OK 73112
1-405-717-8780 or 1-800-752-9475 or TDD 1-405-949-2281 or 1-866-447-0436

THIS FORM SHOULD BE RETURNED TO YOUR INSURANCE/BENEFITS COORDINATOR FOR THEIR REVIEW AND FORWARDING TO OSEEGIB 30 DAYS PRIOR TO YOUR LAST DAY OF EMPLOYMENT TO ENSURE CONTINUOUS COVERAGE.

Oklahoma State and Education Employees Group
Insurance Board (OSEEGIB)

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 THIS NOTICE 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 group's 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 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.sib.ok.gov and www.healthchoiceok.com

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, 1-405-717-8701, toll-free 1-800-543-6044, TDD 1-405-949-2281, 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, TX 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