OKHEEI/NOC
Benefit Election Form
January 1, 2017 - December 31, 2017

SECTION 1: EMPLOYEE INFORMATION

Name (Last, First, M.I.)	Institution	SSN
	NOC	

Mailing Address	City/State	Zip Code

Main Phone Number	DOB	Gender	Marital Status	Hire Date	Benefits Effective Date	Employment Type
						☐ Active ☐ Retired Under 65 ☐ Vested

SECTION 2: ENROLLMENT EVENT

☐ New Hire Enrollment ☐ Open Enrollment ☐ Other Change(s) ☐ Qualifying Life Event Event Date:_____

Event

☐ Marriage ☐ Birth/Adoption/Foster Care ☐ Divorce ☐ Death ☐ Loss of Other Coverage ☐ Court Order

☐ Information Change ☐ Cancel Member Coverage Reason: _____ ☐ Other Reason: _____

SECTION 3: INSURANCE COVERAGE (mark appropriate choices)

BCBSOK - Group # 600600	Delta Dental - Group # 6441	VSP - Group #30017046	Metropolitan Life Insurance Company (MetLife)* - Group #161809			MetLife* - Group #164106	
Medical	**Dental**	**Vision**	**Basic Life/ADD[1]**	**Voluntary Life/ADD[1]**	**Voluntary Dep. Life/ADD[2&3]**	**LTD Core**	**LTD Buy-up**
☐ WAIVE ☐ Red Plan ☐ White Plan ☐ Blue Plan ☐ EE Only ☐ EE+1CH ☐ EE+2+CH ☐ EE+SP ☐ EE+Fam	☐ WAIVE ☐ High ☐ Low ☐ Preventive ☐ EE Only ☐ EE+1CH ☐ EE+2+CH ☐ EE+SP ☐ EE+Fam	☐ WAIVE ☐ EE Only ☐ EE+1CH ☐ EE+2+CH ☐ EE+SP ☐ EE+Fam	☑ Elect (2X annual salary up to $250k) - No cost to EE	☐ WAIVE ☐ Elect $_____	☐ WAIVE w/o AD&D: ☐ Opt. 1 ☐ Opt. 2 ☐ Opt. 3 w/ AD&D: ☐ Opt. 4 ☐ Opt. 5 ☐ Opt. 6	☑ Elect - No cost to EE	☐ WAIVE ☐ Elect

* For any enrollment in a MetLife plan after the initial enrollment period, a statement of health (SOH) must be completed. Contact Human Resources for a copy of the SOH form.

[1]EE Voluntary Life is available in $10,000 increments, up to three times salary or $500,000 (whichever is less) with a guaranteed issue of $300,000 (during new hire enrollment).

[2]Opt 1: $10k Sp & $5k Ch - Life Only; Opt 2: $20k Sp & $10k Ch - Life Only; Opt 3: $50k Sp & $10k Ch - Life Only

[3]Opt 4: $10k Sp & $5k Ch - Life & ADD; Opt 5: $20k Sp & $10k Ch - Life & ADD; Opt 6: $50k Sp & $10k Ch - Life & ADD

See MetLife Certificate for more information on Life and Disability coverage. See MetLife Coverage Conditions for meaning of remaining superscript.

FF![[9at[h¸99{ ² Ih ² !L±9 a95L/![a¦{¢ twh±L59 twhhC hC h¢I9w Lb{¦w!b/9FF

Employee Last Name: _____ SSN: _____ - _____ - _____

SECTION 5: DEPENDENT INFORMATION

All dependents must be enrolled with the same coverage option as the employee selects. Valid dependents are legally married or common law spouse of the same or opposite sex and children in which you or your spouse are legally and financially responsible up to age 26.

1) Dependent Name (Last, First, M.I.)			Relation	Status	Health	Dental	Vision	Dep. Life
				☐ Keep ☐ Add ☐ Drop	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent SSN	DOB	Gender	Disabled?					
Dependent Address								
City, State Zip Code			Phone					

2) Dependent Name (Last, First, M.I.)			Relation	Status	Health	Dental	Vision	Dep. Life
				☐ Keep ☐ Add ☐ Drop	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent SSN	DOB	Gender	Disabled?					
Dependent Address								
City, State Zip Code			Phone					

3) Dependent Name (Last, First, M.I.)			Relation	Status	Health	Dental	Vision	Dep. Life
				☐ Keep ☐ Add ☐ Drop	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent SSN	DOB	Gender	Disabled?					
Dependent Address								
City, State Zip Code			Phone					

4) Dependent Name (Last, First, M.I.)			Relation	Status	Health	Dental	Vision	Dep. Life
				☐ Keep ☐ Add ☐ Drop	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent SSN	DOB	Gender	Disabled?					
Dependent Address								
City, State Zip Code			Phone					

Employee Last Name: _____ SSN: ___ - ___ - ____

SECTION 6: BENEFICIARY INFORMATION

I designate the following person(s) as primary and contingent beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation, any previous designation of a beneficiary for such coverage is hereby revoked. I understand I have the right to change this designation at any time. I also understand that, unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Employee. Payment will be made in equal shares or all to the survivor, unless otherwise specified.

If beneficiary information is different for basic and voluntary life insurance (as applicable), please notate below.

Beneficiary Name, Address, & Phone	Relation	DOB	SSN	Type	%
				☐ Primary ☐ Contin.	
Beneficiary Name, Address, & Phone	Relation	DOB	SSN	Type	%
				☐ Primary ☐ Contin.	
Beneficiary Name, Address, & Phone	Relation	DOB	SSN	Type	%
				☐ Primary ☐ Contin.	
Beneficiary Name, Address, & Phone	Relation	DOB	SSN	Type	%
				☐ Primary ☐ Contin.	
Beneficiary Name, Address, & Phone	Relation	DOB	SSN	Type	%
				☐ Primary ☐ Contin.	

SECTION 7: SIGNATURE

• **IMPORTANT:** Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, provides false information herein and makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

• I authorize the necessary payroll deductions by my Employer, if any, to cover the cost of my coverage(s). I understand that I cannot change my enrollment elections during the plan year, unless a Qualified Life Event (QLE) occurs, in which case, I will notify my employer within 31 days to change my enrollment. I further understand that, if I do not contact my employer within the allotted QLE timeframe, I cannot change my enrollment status until open enrollment.

• I acknowledge that I have read and understand the Fraud and Warning Statements, as well as the coverage policies attached to this document relating to the specific requirements of Blue Cross Blue Shield, MetLife, VSP, and Delta Dental.

• I attest that the information provided above is true and correct to the best of my knowledge. This authorization replaces any previous authorization I have made.

Employee Signature: _____	Date: _____

FRAUD WARNING STATEMENTS

The laws of several states require the following statements to appear on the enrollment form:

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island, and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: Any person knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, and Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York (only applies to Accident and Health Benefits): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

Puerto Rico: Any person who knowingly and with intent to defraud includes false information in an application for insurance or files, assists, or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and, if found guilty, shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

BLUE CROSS BLUE SHIELD COVERAGE CONDITIONS

- I am an employee of the Employer named in this Enrollment Application. I am eligible to participate in the coverage(s) afforded by my Employer's plan, which is either underwritten or administered by Blue Cross and Blue Shield of Oklahoma (BCBSOK). On behalf of myself and any dependents listed on this Enrollment Application, I apply for those coverage(s) for which I am eligible. I state that the information given on this Enrollment Application is true and correct. I understand and agree that any intentional misrepresentation of a material fact made by me will invalidate my coverage(s).
- Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this Enrollment Application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contracts(s)/Plan(s).
- I agree that my Employer acts as my agent. I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s).
- I understand that my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my Employer are applicable to me.

METLIFE COVERAGE CONDITIONS

1. Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance.
2. For Vermont and Washington State Residents, Spouse includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners, or reciprocal beneficiaries with a government agency or office where such registration is available.
3. Amounts will be subject to state limits, if applicable.

*** For any enrollment in a MetLife plan after the initial enrollment period, a statement of health (SOH) must be completed. Contact Human Resources for a copy of the SOH form. EE Voluntary Life is available in $10,000 increments, up to $500,000 with a guaranteed issue of $300,000 (during new hire enrollment). See MetLife Certificate for more information on Life and disability coverage.**

• I declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life insurance, that I was actively at work for at least 20 hours during the 7 calendar days preceding my date of enrollment. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
• I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.
• I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.
• I understand that if I do not enroll for life or disability coverage during the initial enrollment period, or if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.
• I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
• I have read the applicable Fraud Warning(s) provided in this enrollment form.

DELTA DENTAL COVERAGE CONDITIONS

• All companies part of the Delta Dental of Oklahoma family of companies (referred to in this Privacy Policy as "Delta Dental") believe that personal information collected about our customers, subscribers, potential customers, and proposed subscribers (referred to collectively in this Privacy Policy as "Customers") must be treated with the highest degree of confidentiality. For this reason and in compliance with the Gramm-Leach-Bliley Act of companies are able to choose how they share your personal information, however Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
• Information We Collect - We collect and maintain personal, nonpublic information we receive from Customers directly, through applications, enrollment forms, check, credit or debit card payments, insurance claims, and our website. We also collect your personal information from other companies. The types of personal information we collect and share depend on the product or service you have with us. This information can include your name, address, social security number, date of birth, transaction and claim history, medical information, and checking account information.
• Utilization Of Information - Delta Dental has, and will continue to utilize non-affiliated third parties to conduct certain functions of our business in order to provide our Customers with services and products. These functions include processing your requests, claims and transactions, maintaining your account(s), providing information about new products, responding to court orders and legal investigations, reporting to credit bureaus, and to comply with Federal and State Laws. The information Delta Dental uses to provide a service cannot be restricted by our Customers. However, Delta Dental is able to limit this information on your behalf under HIPAA.
• Federal law gives consumers the right to limit information sharing in relation to affiliates' everyday business purposes, information about your creditworthiness, affiliates using your information to market to you, and nonaffiliates using your information to market to you. In addition, state laws and other individual companies may give you additional rights to limit sharing.
• Delta Dental does not have any affiliates, nor do we share information with non-affiliates for marketing purposes. When you are no longer our Customer, we will continue to share your information as described in this notice.
• Our Security - To protect your personal information from unauthorized access and use, we maintain physical, electronic, and procedural safeguards that comply with Federal Law, including computer safeguards and secured files and buildings. We consider nonpublic personal information to be confidential, and treat it as such. The personnel who have access to this information are trained in proper handling of such information. Employees who violate this strict level of confidentiality are subject to our disciplinary process.
• While we do make available certain nonpublic personal information to non-affiliated third parties in order to service Customer accounts, all information is strictly governed by confidentiality and security agreements to protect our Customers. Therefore, our Customer's confidential information is protected.
• If the group plan is terminated or you terminate your coverage, Delta Dental will adhere to the information practices as described in this notice.
• If you have any questions about our Privacy Policy, please do not hesitate to contact your Delta Dental representative at 800-522-0188 (Toll Free) or 405-607-2100 (OKC Metro).
• Under no circumstances will we sell information about our Customers or their account to any unaffiliated company, group, or individual without our Customer's permission.