SURVIVING SPOUSE ENROLLMENT PACKET

Contents and Instructions

Please complete the enclosed election form and return pages 1-5 to Employee Benefits at:

Email: employee.benefits@okc.gov
Fax: (405) 297-2565
Mail: 420 W. Main, Ste 110, Oklahoma City, OK, 73102

Employee Benefits Division
Employee.benefits@okc.gov | (405) 297-2144

City of Oklahoma City

Employee/Retiree ID _____

Surviving Spouse Insurance Enrollment Form

SURVIVOR INFORMATION SECTION (mark N/A if question does not apply):					
Name First MI Last			□ Male □ Female	Date of Birth (MM/DD/YYYY)	
Social Security Number	Medicare Effective Date	□ Part A □ Part B	Primary Care Physician (HMO only)		
Physical Address (required) Street			City	State	Zip Code
Mailing Address (optional) Street			City	State	Zip Code
Home Telephone Number	Mobile Telephone Number		Preferred Method of Contact □ Home □ Mobile		
Email Address (Optional)	Retirement Date		Occupation		

YOUR MEDICAL INSURANCE COVERAGE

Select your level of medical insurance coverage:

☐ Waive Coverage (Skip to Dental Insurance Coverage) ☐ For Myself ☐ For Myself and Child(ren)*

Select from 1 of the 3 options below (Options 1 and 2 are Medicare Rates, Option 3 is Non-Medicare Rates):

1) If **YOU [and] ALL COVERED DEPENDENT(S)** are enrolled in Medicare Part A and Part B, select from the following plans:

☐ Medicare Advantage Plan PPO** ☐ BCBS Alternate PPO ($750 Ded.) ☐ BCBS Standard PPO ($250 Ded.)

2) If **YOU [or] A COVERED DEPENDENT** are Medicare eligible*, select from the following plans:

☐ BCBS Alternate PPO ($750 Ded.) ☐ BCBS Standard PPO ($250 Ded.)

3) If **YOU [and] ALL COVERED DEPENDENT(S)** are not eligible for Medicare, select from the following plans:

☐ BCBS PPO ($750 Ded.) ☐ BCBS PPO ($250 Ded.) ☐ BCBS EPO

Complete Child Dependent Information on Page 2* ***If you have End-Stage Renal Disease (ERSD), contact Employee Benefits

YOUR DENTAL INSURANCE COVERAGE

Select your level of dental insurance coverage: ☐ Waive Coverage (Skip to Vision Insurance Coverage)

☐ For Myself ☐ For Myself and One Dependent ☐ For Myself and Two or More Dependents

Select your Dental Plan Option:

☐ BCBS Dental (Low Plan Option) ☐ BCBS Dental (High Plan Option)

YOUR VISION INSURANCE COVERAGE

Select your level of Vision insurance coverage: ☐ Waive Coverage (Skip to Life Insurance Coverage)

☐ For Myself ☐ For Myself and One Dependent ☐ For Myself and Two or More Dependents

DEPENDENT CHILD(REN) INFORMATION SECTION:
(Complete only if continuing coverage for child(ren) Eligibility rules may apply.)

Name First MI Last			☐ Male ☐ Female	Date of Birth (MM/DD/YYYY)
Social Security Number	Medical ☐ Yes ☐ No	Dental ☐ Yes ☐ No	Vision ☐ Yes ☐ No	Primary Care Physician (HMO only)
Name First MI Last			☐ Male ☐ Female	Date of Birth (MM/DD/YYYY)
Social Security Number	Medical ☐ Yes ☐ No	Dental ☐ Yes ☐ No	Vision ☐ Yes ☐ No	Primary Care Physician (HMO only)
Name First MI Last			☐ Male ☐ Female	Date of Birth (MM/DD/YYYY)
Social Security Number	Medical ☐ Yes ☐ No	Dental ☐ Yes ☐ No	Vision ☐ Yes ☐ No	Primary Care Physician (HMO only)
Name First MI Last			☐ Male ☐ Female	Date of Birth (MM/DD/YYYY)
Social Security Number	Medical ☐ Yes ☐ No	Dental ☐ Yes ☐ No	Vision ☐ Yes ☐ No	Primary Care Physician (HMO only)

Documentation Requirements

Medical, Dental, and Vision coverage will not be established for eligible dependent child(ren) until the following documents below are submitted. You have 31 days from your retirement date to comply with this requirement. Failure to timely submit required documents will result in non-enrollment of your dependents, which may result in the dependent child(ren) being ineligible for future coverage. Additional information on dependent eligibility may be found in the Retiree Guide to Benefits and www.okc.gov/retirees.

CHILD(REN)

Copy of State Issued Birth Certificate, Copy of SSN Card, and Copy of Medicare Card (if applicable)

Medicare Requirements

If you and/or a covered dependent become eligible for Medicare, you are required to notify Employee Benefits within 31 days of your Medicare eligibility date. Failure to notify Employee Benefits of Medicare eligibility may result you being enrolled in an incorrect plan and/or overpaying of premiums. Employee Benefits will not be responsible for refunding overpayment of insurance premiums as a result of failure to notify Employee Benefits within 31 days of Medicare eligibility.

Life Events Requirements

If you and dependent child(ren) experience a life event, it is your responsibility to notify Employee Benefits within 31 days of the event date. Failure to notify within 31 days may result in the OPEBT/City subsidizing coverage for an ineligible dependent. In addition, failure to notify of other Life events within the initial 31 days after a life event may result dependent child(ren) being ineligible for future coverage.

In the event of an ineligible dependent child(ren) coverage, Employee Benefits reserves the right to re-adjudicate paid claims and/or demand reimbursement of premiums paid by OPEBT/City on behalf of ineligible dependent child(ren). Examples of Life events include, but is not limited to: Divorce, Death, Gaining Other Insurance Coverage, Marriage, and Birth.

COBRA Continuation Coverage may be available upon loss of coverage, and that I may refer to the General Notice of COBRA Continuation Coverage Rights for more information.

Contact Employee Benefits at employee.benefits@okc.gov or (405) 297-2144 if you have any questions regarding your rights and responsibilities as a surviving spouse. Additional information may be found in the Retiree Guide to Benefits as well as www.okc.gov/retirees.

I hereby attest, by signature below, electronic signature, or default (no action taken), that I have read and/or been provided a copy of the Documentation Requirements, Medicare Requirements, and Life Events Requirements. I furthermore acknowledge that by my election of coverage, it is my responsibility to comply with the Requirements stated above.

I hereby attest, by signature below, electronic signature, or default (no action taken), that the information listed on this form is true and correct. I further acknowledge that I am legally responsible for the medical/dental expense incurred by individuals listed on this form in the event such expenses are not covered under the selected medical/dental plans. I understand that if the information on this form is determined to be false or misleading, it may result in denial of benefits and termination of my or my dependent's coverage as well as any other action deemed appropriate.

Premium payment for health, dental, and vision insurance will be deducted from your pension check. Retirees are paid on the last day of the month; therefore, premiums are deducted in arrears. If the total amount of monthly premium contributions exceeds the amount of your pension check please contact the Employee Benefits Division at 297-2144 to make payment arrangements.

OCERS RETIREES ONLY: I hereby authorize my contribution amounts to be deducted from my pension check at the rates established now or in the future. I also understand that I cannot change contribution amounts or revoke this agreement during the plan year except by written request to terminate Major Medical or there is a permitted qualifying event. I agree to provide timely notification and documentation to the Employee Benefits Division if I or my dependent(s) become covered under Medicare/Medicaid or other employer coverage.

POLICE RETIREES ONLY: Any election and/or change to your benefit elections may require you to complete Form 135 and submit to Oklahoma Police Pension and Retirement System (OPPRS). Any shortage in premiums paid may result in coverage termination of benefit. Any overpayment of premiums may not be refunded until validation of the correct premium payment is submitted to OPEBT/City.

Additional information regarding your retiree benefits can be found in the Retiree Guide to Benefits and at www.okc.gov/oe .

_____ _____

Surviving Spouse Signature **Date**

_____ _____

Name **Date**

Retiree ID _____

Surviving Spouse Name_____

City of Oklahoma City

Supplemental Waiver Acknowledgement Form

As a surviving of spouse of the City retiree, you have the right to elect the following benefits at the time of initial enrollment:

Major Medical
Dental
Vision

Medical

Medical insurance requires continuous enrollment in an OPEBT/City-sponsored medical plan to maintain eligibility. If you waive medical coverage either at the time of retirement (initial enrollment), you will not be eligible to enroll in medical coverage at a later date.

In addition, you can terminate their Medical Insurance voluntarily at any time with signed authorization. The termination of coverage will take effect the first of the month following receipt of the signed authorization to terminate coverage. You will not be permitted to enroll in Medical.

NOTE: *If you and/or spouse are currently a Full-Time City employee or rehired at a later date as a Full-Time City employee and choose to elect medical coverage as an active employee or as a spouse of an active employee under a City-sponsored medical plan and are covered under the Active Employer-paid Group Life plan, you must notify employee benefits within 31 days of date your active benefits begin. You will have the right to waive retiree Medical coverage during the time you gain coverage as an active Full-Time employee. Once you separate employment with the City, you have 31 days to re-elect your retirement benefits in order to maintain continuous coverage under an OPEBT/City sponsored plan.*

Dental and Vision

Current policy allows for you to waive and re-elect dental and vision coverage at Open Enrollment or within 31 days of a loss of coverage. If you waive all coverage at initial enrollment or at a later date, Employee Benefits may choose to suppress the mailing of the future Guide to Benefits and election forms. If you wish to re-enroll in dental and/or vision, contact Employee Benefits at employee.benefits@okc.gov or (405)297-2144 during the month of October. The policy to allow enrollment and disenrollment in dental and vision may be revoked at any time at the discretion of OPEBT/City.

I hereby attest, by signature below, electronic signature, or default (no action taken), that I have read and/or been provided a copy of the Supplemental Waiver Acknowledgement Form and understand my rights and responsibilities regarding the election and waiver of coverage. I acknowledge that if I waive Medical coverage other than to maintain coverage in a City sponsored medical plan during my employment as a full-time City employee), I will not be eligible to re-elect Medical coverage at a future date.

_____ _____

Surviving Spouse Signature **Date**

City of Oklahoma City

SURVIVING SPOUSE COPY

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