OKHEEI

Benefit Election Form

January 1, 2019 - December 31, 2019

SECTION 1: EMPLOYEE INFORMATION

Name (Last, First, M.I.)	Institution	SSN	
Mailing Address		**City/State**	**Zip Code**

Main Phone Number	DOB	Gender	Marital Status	Benefit Effective Date	Retirement Date	Member Type
						☐ Retired Over 65 ☐ Retired Under 65 ☐ Spouse of Retiree

SECTION 2: MEDICARE INFORMATION (Post-54 Retirees Only)

Medicare Number: _____ Medicare Part A Effective Date: _____/_____/_____

Medicare Part B Effective Date: _____/_____/_____

****NOTE: A separate form for Medicare changes will need to be completed for a Mediare-Eligible Spouse****

SECTION 3: INSURANCE COVERAGE (mark appropriate choices)

BCBSOK - Group # 600600	United Healthcare	Delta Dental - Group # 6441	VSP - Group #30017046
Non-Medicare Eligible Medical	**Medicare Eligible Medical**	**Dental**	**Vision**
Check the box next to all individuals that should have Non-Medicare Eligible Medical Coverage	Check the box next to all individuals that should have Non-Medicare Eligible Medical Coverage		
☐ Waive ☐ Plan A ☐ Retiree ☐ Plan B ☐ Spouse ☐ Plan C ☐ Child ☐ Plan D ☐ Children ☐ Plan E ☐ Family ☐ Plan E HSA	☐ WAIVE ☐ Sr. Supplement Only ☐ Retiree ☐ Sr. Supp w/Part D Low ☐ Spouse ☐ Sr. Supp W/Part D High ☐ Child ☐ Children ☐ Family	☐ WAIVE ☐ High ☐ Low ☐ Preventive ☐ Retiree ☐ Spouse ☐ Child ☐ Children ☐ Family	☐ WAIVE ☐ Retiree ☐ Spouse ☐ Child ☐ Children ☐ Family

* You (the retiree) MUST be enrolled in a Medical Plan (whether UHC or BCBS) to receive the subsidy through OTRS. You do not have to enroll in Dental, Vision, or a Pharmacy benefit through OKHEEI to keep this subsidy.

* If You drop or waive medical or vision plans, you cannot re-enroll at a later date without a Qualifying Life Event.

SECTION 5: DEPENDENT INFORMATION

All dependents must be enrolled with the same coverage option 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. Chard Snyder/OKHEEI reserves the rigth to verify the eligiblity status of any dependent added to the plan.

1) Dependent Name (Last, First, M.I.)	Relation	DOB	Health	Dental	Vision
			☐ Keep ☐ Add ☐ Drop	☐ Keep ☐ Add ☐ Drop	☐ Keep ☐ Add ☐ Drop
SSN	Gender	Disabled?			
Dependent Address (if different)					
City, State Zip Code	Phone				

2) Dependent Name (Last, First, M.I.)	Relation	DOB	Health	Dental	Vision
			☐ Keep ☐ Add ☐ Drop	☐ Keep ☐ Add ☐ Drop	☐ Keep ☐ Add ☐ Drop
SSN	Gender	Disabled?			
Dependent Address (if different)					
City, State Zip Code	Phone				

3) Dependent Name (Last, First, M.I.)	Relation	DOB	Health	Dental	Vision
			☐ Keep ☐ Add ☐ Drop	☐ Keep ☐ Add ☐ Drop	☐ Keep ☐ Add ☐ Drop
SSN	Gender	Disabled?			
Dependent Address (if different)					
City, State Zip Code	Phone				

*Important: any person who knowingly and with intent to injure, defraud or deceive any isurer, 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 understand that if I waive or drop coverage, I cannot re-enroll in medical, dental or vision unless I have a Qualifying Life Event.

*I understand that by waiving retiree medical coverage through BCBS and/or UHC through OHKEEI, I am waiving my right to my OTRS subsidy and will not be able to enroll at a later date.

*I understand that if I waive Mediare Part D plan through OKHEEI, I will need to obtain a Part D plan through another source or I could be penalized by the Centers for Medicare and Medicaid.

*I authorize the necessary direct deposit deductions by Chard Snyder, if any, to cover the cost of my coverages(s). I understand that I cannot change my enrollment elections during the plan year without a Qualifying Life Event, (QLE), in which case I will notify Chard Snyder within 31 days to change my enrollment. I further understand that, if I do not contact Chard Snyder 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 statement, as well as the coverage policies attached to this document relating to the specific requirements of Blue Cross Blue Shield, UHC, Delta Dental and VSP.

*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.

Retiree (or spouse) Signature: _____ Date: _____

Mail Completed form to:
Chard-Snyder Benefit Solutions
6867 Cintas Boulevard
Mason, OH 45040