



# EMPLOYEE CHANGE FORM

Mailing Address:  
PO Box 549  
Stillwater, OK 74076

Medical, Dental,  
Vision and Life

## Employee Information (Change of name and address)

Your Name (Last, First, Middle Initial)		Social security number	
New Name (Last, First, Middle Initial)		New Email Address	
Your New Address (Street)	(city)	(state)	(ZIP)

## Complete for Adding or Cancelling Coverage

Medical, Dental & Vision	<input type="checkbox"/> add	<input type="checkbox"/> employee	<input type="checkbox"/> spouse	<input type="checkbox"/> children
	<input type="checkbox"/> cancel	<input type="checkbox"/> employee	<input type="checkbox"/> spouse	<input type="checkbox"/> children

In the past twelve months, have you, the applicant, had continuous group orthodontia coverage with a prior carrier?  
 Yes  No

## Reason for Adding a Dependent

<input type="checkbox"/> marriage	<input type="checkbox"/> loss of other group coverage*	<input type="checkbox"/> open enrollment*	Date of Event
<input type="checkbox"/> birth/adoption	<input type="checkbox"/> court order (attach a copy)	<input type="checkbox"/> other	_____

## Reason for Cancelling a Dependent

<input type="checkbox"/> divorce	<input type="checkbox"/> spouse's group coverage	<input type="checkbox"/> Medicare	Date of request / ineligibility
<input type="checkbox"/> age limit	<input type="checkbox"/> individual insurance	<input type="checkbox"/> other _____	_____

## Complete for Adding or Cancelling a Dependent (Include last name if different from the employee)

Spouse's name	Birth date	Gender <input type="checkbox"/> male <input type="checkbox"/> female	Social security number	
Name(s) of child(ren)	Birth date	<input type="checkbox"/> male <input type="checkbox"/> female	Social security number	Foster Child? <input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> male <input type="checkbox"/> female		Foster Child? <input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> male <input type="checkbox"/> female		Foster Child? <input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> male <input type="checkbox"/> female		Foster Child? <input type="checkbox"/> Yes <input type="checkbox"/> No

\*If you checked foster child, do you provide principal support and does the child(ren) live with you at least 50% of the time?  
 Yes  No

\*For loss of other group coverage and open enrollment, you must complete the following:

Name of prior medical carrier	Date Coverage Ended
Name of prior dental carrier	Date Coverage Ended
Name of prior life carrier	Date Coverage Ended

**Important - Complete Front and Back of this form.**



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**Beneficiary Designation** (Complete if adding life coverage or changing beneficiary.)

Full name	Relationship	Percentage %
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**Contingent Designation** (Complete if adding life coverage or changing beneficiary.)

Full name	Relationship	Percentage %
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If two or more beneficiaries are named, proceeds shall be paid in equal shares to the surviving beneficiaries, unless specified otherwise. If no beneficiary has been named, any proceeds will be payable as provided by the group policy.

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**Employee Signature** (Read and sign below)**I understand and agree with the following statements:**

- My dependents are not eligible for any coverage for which I am not covered.
- My dependents, including stepchildren, foster children and those over the maximum age, are eligible for coverage based on policy provisions. Eligibility for my dependents over the maximum age will be verified when claims are submitted.
- **If I cancel medical coverage for myself and/or my dependents, and then request coverage at a later date, I and/or my dependents will be considered a late enrollee. As a late enrollee, I and/or my dependents may not enroll until the next annual open enrollment period and/or may be subject to the preexisting condition exclusion. (Exception: in MD and MN, the annual open enrollment period does not apply. Late enrollees will be subject to the preexisting condition exclusion.) However, I will not be considered a late enrollee for employee and/or dependent coverage (and will not have to wait until the next annual open enrollment period) if: (a) enrollment right; and (c) any required information or proof is furnished. Refer to your booklet for more details.**
- If I cancel coverage, I cannot under any circumstance enroll in the policy once I have retired.
- If the group policy requires that I make contributions, I authorize my employer to deduct them from my pay.
- If I knowingly provide false or misleading information, I may be guilty of insurance fraud, which is punishable by law.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

I declare that the information I have completed on this change form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from Blue Cross Blue Shield, Delta Dental, Vision Service Plan or The Hartford.

Your signature X \_\_\_\_\_

Date signed \_\_\_\_\_



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## **INITIAL NOTICE ABOUT SPECIAL ENROLLMENT RIGHTS AND PREEXISTING CONDITION EXCLUSIONS IN YOUR GROUP HEALTH PLAN**

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A federal law called HIPAA requires that we notify you about two very important provisions in the plan. The first is your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons. Second, this notice advises you of the plan's preexisting condition exclusion rules that may temporarily exclude coverage for certain preexisting conditions that you or a member of your family may have.

### **I. Special Enrollment provision**

**Loss of other Coverage.** If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

**New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.** In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact your group administrator.

### **II. Preexisting Condition Exclusion Rules**

This plan imposes a preexisting condition exclusion. That means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applied only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period prior. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan or who has other creditable coverage within 31 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage (HIPAA Certificates) you have. If you do not have a Certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show that you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

**Blue Cross and Blue Shield of Oklahoma has established a toll-free telephone number (1-888-250-2005) to assist you in obtaining certificates of coverage and preexisting condition "credit".**

***Please keep this notice for your records.***