



Insurance Enrollment Form for the 2009 Plan Year - New Enrollees

Select one: Norman Campus Oklahoma City Campus Tulsa Campus

Complete all sections of this form and return this original signed document to your local Benefits Office: **Norman Campus** - Office of Human Resources - 905 Asp Ave., NEL 244, Norman, OK, 73019 - (405) 325-2961 **OKC Campus** - Office of Human Resources, SCB, Rm. 118 - P.O. Box 26901 OKC, OK 73126 - (405) 271-2188. **Tulsa Campus** - Office of Human Resources - 4502 E. 41st. Street, Suite 1C114 - Tulsa, OK, 74135 - (918) 660-3190.

1 Employee Information				
Last:		First:		Middle:
Home address:				
City:		State:		Zip:
SSN:	EMPL ID:	Date of Birth (MM/DD/YY):		Gender:
Home phone:		Work phone:		Email address:

2 Medical Insurance:				
<input type="checkbox"/> BlueChoice PPO	<input type="checkbox"/> BlueEdge HCA	<input type="checkbox"/> BlueLincs HMO	<input type="checkbox"/> Community Care HMO (Tulsa Area only)	<input type="checkbox"/> I Waive Medical Coverage (Proof of coverage required.)
Individuals Covered:	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee and Spouse	<input type="checkbox"/> Employee and Children	<input type="checkbox"/> Employee and Family
Identification Number of Primary Care Physician (PCP) for Employee (For HMO applicants only):				
Spouse PCP # (For HMO applicants only):		Child(ren) PCP # (For HMO applicants only):		

3 Dental Insurance: University provides paid coverage for full-time benefits eligible employees under the Basic Plan Option .				
<input type="checkbox"/> Option One (Basic Plan)		<input type="checkbox"/> Option Two (Alternate Plan)		<input type="checkbox"/> I Waive Dental Coverage
Individuals Covered:	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee and Spouse	<input type="checkbox"/> Employee and Child(ren)	<input type="checkbox"/> Employee and Family

4 Vision Insurance: This is university sponsored optional insurance coverage paid for by the employee.				
<input type="checkbox"/> Option One (Basic Plan)		<input type="checkbox"/> Option Two (Premium Plan)		
Coverage Options:	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee and Spouse	<input type="checkbox"/> Employee and Child(ren)	<input type="checkbox"/> Employee and Family

5 Dependents - List all individuals to be covered by this enrollment.							
Coverage	Name	Relationship	Gender	Date of Birth	SSN	Full Time College Student ?	
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> AD&D						<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> AD&D						<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> AD&D						<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> AD&D						<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> AD&D						<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> AD&D						<input type="checkbox"/> Yes	<input type="checkbox"/> No

Employee: Last:	First:	SSN:
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6 Life Insurance - The university provides paid coverage for full-time employees at the 1.5 times salary level.

NOTE: If coverage selected is more than \$450,000, the additional coverage will NOT be in effect until a supplementary application is completed and approved. You may call the benefits office for a copy of the Life application, or one will be sent upon receipt of this form. See the benefits guide for details.

<input type="checkbox"/> Accept Life Coverage		<input type="checkbox"/> Waive Life Coverage	
Employee coverage options:	Spouse coverage options:	Child(ren) coverage options:	
<input type="checkbox"/> Basic Life 1.5x annual Salary	<input type="checkbox"/> .75x <input type="checkbox"/> 1.5x <input type="checkbox"/> 2.25x <input type="checkbox"/> 3x	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000	
<input type="checkbox"/> Supplemental Life: <input type="checkbox"/> 1.5x <input type="checkbox"/> 3x <input type="checkbox"/> 4.5x	N/A	N/A	

7 AD&D Insurance: (NOTE: Employee coverage is pre-tax. Spouse and child(ren) coverage will be after-tax). University provides paid coverage for full-time employees at the \$20,000 level.

<input type="checkbox"/> Accept AD&D Coverage		<input type="checkbox"/> Waive AD&D Coverage	
Coverage amount for employee \$	Coverage amount for spouse \$	Coverage amount for child(ren) \$	

8 Beneficiary Information - Required for (L) Life Insurance and (A) AD&D Insurance. **NOTE:** Unless indicated on this form, the Employee will be designated as the Primary Beneficiary for all dependent coverage.

Policy	Beneficiary Name	Beneficiary SSN	Date requested	Relationship	Primary or Contingent ?	Initial here
<input type="checkbox"/> L <input type="checkbox"/> A <input type="checkbox"/> Both						
<input type="checkbox"/> L <input type="checkbox"/> A <input type="checkbox"/> Both						
<input type="checkbox"/> L <input type="checkbox"/> A <input type="checkbox"/> Both						
<input type="checkbox"/> L <input type="checkbox"/> A <input type="checkbox"/> Both						
<input type="checkbox"/> L <input type="checkbox"/> A <input type="checkbox"/> Both						
<input type="checkbox"/> L <input type="checkbox"/> A <input type="checkbox"/> Both						

9 Employee Long Term Disability Insurance: Pre-tax After-tax (select one). This is university sponsored optional insurance coverage paid for by the employee.

Coverage Options:	<input type="checkbox"/> Option 1 (66 2/3%)	<input type="checkbox"/> Option 2 (50%)	<input type="checkbox"/> Option 3 (Restricted, see benefits guide)
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10 Long-Term Care Insurance: This is university sponsored optional insurance coverage paid for by the employee. Must be paid with after-tax dollars. Note: Additional insurance application required to enroll in this insurance plan.

Coverage For:	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Spouse Only	<input type="checkbox"/> Employee and Spouse
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11 For Employees With Children

Is another person, other than you or your spouse, legally responsible for your children? Yes No

12 Other Coverage - If you or your dependents are enrolling in university provided medical care, will you or your dependents also be enrolled in any other medical care coverage elsewhere? Yes No. If yes, please list all sources of coverage here.

Name	Insurance Company	Policy Number

Authorization - I represent the information contained on this enrollment form to be complete and accurate to the best of my knowledge. Furthermore, I authorize any health care professional or entity to provide the plan administrators (or their authorized designees) all the information needed to process the necessary insurance claims on my behalf.

Signature	Date:
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