

# Oklahoma Higher Education Employee Insurance Enrollment/Change Form

Employee ID \_\_\_\_\_

Please indicate institution:

- Cameron     ECU     MSC     NOC     NSU     NWOSU     Rogers  
 RUSOAdmin     SE     SSC     SWOSU     UCO     WOSC

New Hire     Change     Reason for change \_\_\_\_\_

Date of Hire \_\_\_\_\_    Coverage Effective Date \_\_\_\_\_    Active     Retired Under 65     Vested

\_\_\_\_\_  
 Last Name                                      First Name                                      MI                                      SS #

\_\_\_\_\_  
 Address                                      City                                      State                                      Zip

Birthdate \_\_\_\_\_     Male     Female     Married     Single    \_\_\_\_\_  
 Phone # \_\_\_\_\_

**Select a BlueCross/BlueShield (BCBS) Medical Plan:** Dependents must be enrolled with same option employee selects.

**BC/BSOK High Option**     **BC/BSOK Basic Option**     **Waive Coverage** (must provide proof of other group insurance)

**BC/BSOK Dental (employee-paid)**     Yes     No

**Vision Service Plan (university-paid)**     Yes     No

**Dependents/Options: Additions or Deletions**

	Add	Drop	Name	Relationship	Birthdate	SSN	M/F
Health							
Dental							
Vision							
Health							
Dental							
Vision							
Health							
Dental							
Vision							
Health							
Dental							
Vision							
Health							
Dental							
Vision							

\_\_\_\_\_  
 Employee Signature

\_\_\_\_\_  
 Date