SUBSCRIBER CHANGE FORM
FOR INSURE OKLAHOMA/O-EPIC
Instructions

1. **Please PRINT** or **TYPE** the information that has changed from the original application. Use only BLUE or BLACK ink to complete this form. Failure to provide complete, accurate information will result in the Change Form being returned. Remember to make copies of the documents you are submitting for your own record.

   For additional assistance or information, call our helpline at **1-888-365-3742** or visit our website at **www.insureoklahoma.org.** For the hearing impaired, call **(405) 416-6848** (TDD/TTY).

2. Refer to the Code Listing Section found at the end of the form for the appropriate codes to use when completing sections requiring a **Code****.

3. Mail to: **Insure Oklahoma/O-EPIC, P.O. BOX 54200, Oklahoma City, OK 73154 - 1200**

REQUIRED

Applicant Name: Last: _____ First: _____ MI: ___ SSN: ____-____-_____

Employer Name: _____

OPTIONAL – Fully complete all sections that have changed.

Change Dependent Information: *Fill out this section completely with dependent's information if your dependent was on the application but not eligible and now wants to apply again.* ***IF*** *dependent was not on the application and now wants coverage, you must complete the End Insure Oklahoma/O-EPIC Eligibility section on the next page and submit a NEW Insure Oklahoma/O-EPIC Subscriber Application. (Make copies of this form as necessary for each dependent)*

Is your dependent applying for Insure Oklahoma/O-EPIC? ☐ Yes ☐ No

Dependent's Name: Last: _____ First: _____ MI: ___

SSN: _____-____-_____ Date of Birth *(mm/dd/yyyy)*: _____/_____/_____ Gender: ☐ Female ☐ Male

Hispanic: ☐ Yes ☐ No Race Code **: _____ Language Code **:_____ Citizenship Code **: _____

Alien Registration # or Admission #: _____ US Entry Date *(mm/dd/yyyy)*: _____/_____/_____

Does this dependent currently have Medicare? ☐ Yes ☐ No

Does this dependent currently have SoonerCare *(e.g. SoonerCare Choice, SoonerPlan, Oklahoma Cares…)*? ☐ Yes ☐ No

Dependent's Primary Employment Information:

Employer Name: _____

Employer Phone: (_____) _____ Total number of Employees working for Employer: _____

Dependent's Other Employment(s): *(if more space is needed, attach additional pages)*

Employer Name: _____

Employer Phone: (_____) _____ Total number of Employees working for Employer: _____

Dependent's PCP choice if applying for Individual Plan: *(Refer to the website at www.insureoklahoma.org for listing of current PCPs)*

ID(s) for PCP Choice: 1st: _____; 2nd: _____; 3rd: _____;

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OPTIONAL – Fully complete all sections that have changed.

Change Contact Information: *Fill out this section completely IF you have a change in **any** contact information.*

Phone Number: (_____) _____ Phone Code**: _____

Email Address: _____

Street Address: Mailing Address: *(if different than Street Address)*

Address 1: _____ Address 1: _____

Address 2: _____ Address 2: _____

City/ State/ Zip: _____/ _____/ _____ City/ State/ Zip: _____/_____/ _____

County of Residence: _____

Change Name(s): *Fill out this section IF you have a change in your name. Complete Last, First and MI for each person with a name change.*

Applicant: Last: _____ First: _____ MI: ____

Dependent: Last: _____ First: _____ MI: ____

Dependent: Last: _____ First: _____ MI: ____

Dependent: Last: _____ First: _____ MI: ____

End Insure Oklahoma/O-EPIC Eligibility*: Fill out this section completely **IF** you voluntarily want to terminate your Insure Oklahoma/O-EPIC eligibility. Note: By completing this section, you have agreed to waive your rights to receive a termination notice at least 10 days before the date of termination is effective.*

Name: Last: _____ First: _____ MI: ___

SSN: _____-____-_____

Termination Reason Code **: _____ When (Month/Year) do you want to end your eligibility? _____/_____ (MM/YYYY)

The information I give on this form is true and correct to the best of my knowledge. I realize if I give information that is not true OR if I withhold information, I can be lawfully punished for fraud or perjury. I may also have to re-pay the State of Oklahoma for any payments or claims incurred which were paid due to my fraud or error. (28 USC 1746)

Signature: _____ **Today's Date:** _____

CODE LISTING SECTION

Race Code: **01 - American Indian or Alaskan Native; **02** - Asian; **03** - Black or African American; **04** - Native Hawaiian or Other Pacific Islander; **05** - White

Language Code: **A - Speaks but cannot read or write English; **E** - Speaks and reads or writes English; **S** - Speaks and reads or writes Spanish; **N** – Does not speak or read English or Spanish

Citizenship Code: **A - Qualified Aliens; **C** - US Citizen; **D** - Qualified Alien - deportation withheld; **E** - Eligible alien; **F** - Qualified alien – refugee; **M** - Qualified alien - veterans/active duty military; **N** - Ineligible alien; **O** - Illegal alien; **P** - Alien legalized under Section 245A; **R** - Alien legalized under Section 210; **S** - Alien legalized under Section 210A; **T** - Alien legalized under Section 902

Phone Code: **B - No Phone; **H** - Home; **N** - Neighbor; **O** - Other; **P** - Pager; **R** - Relative; **W** - Work

Termination Reason Code: **001 - Death; **003** – No longer Employed with the eligible employer; **004** - Divorced; **011** - Moving to another state; **013** - Never had insurance; **017** - Other