# OSU/A&M RETIREE ELECTION FORM

## PERSONAL INFORMATION – Please Print

CWID or SSN: ___ ___ ___ ___ ___ ___ ___ ___ ___ Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Home Telephone: _____

Email: _____ Effective Date: _____

## HEALTH PLAN – BlueCross BlueShield ☐KEEP ☐DROP

☐ BlueOptions ☐ BlueEdge High Deductible ☐ Medicare (Age or Disability) *

*Age 65 and over; or Medicare eligible based on disability, must sign up for Medicare A and B; then complete and submit enrollment applications for BCBS Supplemental and BlueRx plans to OSU Benefits, within 60-90 days prior to retirement.

## DENTAL PLAN – Delta Dental of Oklahoma ☐KEEP ☐DROP

☐ Low Plan ☐ High Plan ☐ Platinum Plan

## VISION PLAN – Vision Service Plan (VSP) ☐KEEP ☐DROP

☐ Base Plan ☐ Buy-Up Plan

## DEPENDENT INFORMATION

| | | | KEEP | DROP |
|---|---|---|---|---|
| **SPOUSE:** | Name: _____ | SSN: _____ | | |
| | Date of Birth: _____ | Gender: M F | ☐ | ☐ Health |
| | | | ☐ | ☐ Dental |
| | | | ☐ | ☐ Vision |
| **CHILD:** | Name: _____ | SSN: _____ | | |
| | Date of Birth: _____ | Gender: M F | ☐ | ☐ Health |
| | | | ☐ | ☐ Dental |
| | | | ☐ | ☐ Vision |
| **CHILD:** | Name: _____ | SSN: _____ | | |
| | Date of Birth: _____ | Gender: M F | ☐ | ☐ Health |
| | | | ☐ | ☐ Dental |
| | | | ☐ | ☐ Vision |

**IMPORTANT INSTRUCTIONS: To elect pre-Medicare retiree health coverage, complete this Election Form and return it to OSU Benefits. The form needs to be received by OSU Benefits by the end of the month in which you retire. If you do not submit this form, you will lose your right to elect retiree coverage. Also, you will not be eligible for the OTRS health credit if applicable.**

I understand that PlanSource will bill me and my monthly premiums are due from the effective date of retiree insurance and must be paid by the 1st of the month for that month's coverage. If payment is not received by the end of the month, coverage will be cancelled.

**SIGNATURE:** _____ **DATE:** _____

For questions regarding retiree insurance, please contact OSU Benefits at 405-744-5449, osu-benefits@okstate.edu. Fax: 405-744-8345 or Mail completed form to: Oklahoma State University, Attn: Benefits, 201 GAB, Stillwater, OK 74078