



## RETIREE DECLINING HEALTH INSURANCE FORM

<b>EMPLOYER INFORMATION</b>			
Employer (with campus)			
<b>RETIREE INFORMATION</b>			
Last Name	First Name	Middle Name	
Address	City	State	Zip
Social Security Number _ _ - _ - _ - _ - _	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Retirement Date	

As I decline retiree health coverage, I acknowledge the following consequences:

- I lose the right to enroll at a later date; and
- If I am an Oklahoma Teacher's Retirement System retiree, I may lose the OTR partial payment of the health insurance premium as part of my retirement benefit.

<b>STATEMENT</b>	
I have been offered the benefit of staying with BlueCross BlueShield as a retiree and have elected not be covered. I understand the consequences and do not wish to enroll.	
<b>RETIREE SIGNATURE</b>	<b>DATE</b>