



OSU/A&M Pre-Medicare Retiree Election Form

PERSONAL INFORMATION – Please Print

CWID or SSN: _____ Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Email: _____

Please circle your associated institution: CSC LU NEO OPSU OSU

☐ I am the spouse or dependent of Retiree _____ (name of retiree)

OAMC System Health Plan

☐ KEEP

☐ DECLINE

☐ PPO

☐ High Deductible

☐ Medicare* (Age or Disability)

Declining these plans is an irrevocable decision and will forfeit your OTRS subsidy.

*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 Rx plans to OSU Benefits, within 30-60 days prior to retirement.

DENTAL PLAN – Delta Dental of Oklahoma

☐ KEEP

☐ DECLINE

☐ Low Plan

☐ High Plan

☐ Platinum Plan

VISION PLAN – Vision Service Plan (VSP)

☐ KEEP

☐ DECLINE

☐ Base Plan

☐ Buy-Up Plan

DEPENDENT INFORMATION

SPOUSE:

Name: _____ SSN: _____

KEEP

DROP

Date of Birth: _____ Gender: M F

☐
☐
☐

☐ Health
☐ Dental
☐ Vision

CHILD:

Name: _____ SSN: _____

KEEP

DROP

Date of Birth: _____ Gender: M F

☐
☐
☐

☐ Health
☐ Dental
☐ Vision

CHILD:

Name: _____ SSN: _____

KEEP

DROP

Date of Birth: _____ Gender: M F

☐
☐
☐

☐ Health
☐ Dental
☐ Vision

I authorize OSU/A&M to make the changes indicated on this form and bill me for any applicable premiums. I understand that benefits are subject to cancellation for non-payment.

SIGNATURE: _____ DATE: _____

Return form by mail to OSU Benefits, 201 General Academic Building, Stillwater, OK 74078, or email to osu-benefits@okstate.edu, or Fax: 405-744-8345