

OSU/A&M Medicare Prescription Drug Plan (PDP) Retiree Enrollment Form

Complete and return this form to OSU/A&M Benefits to enroll in the PDP Basic plan.

Group #: OKRXB

Effective Date: ____ / 01 / 2 0 ____

Please circle your associated institution: CSC LU NEO OPSU OSU

I am the Retiree ☐ I am the Spouse/Dependent of a Retiree ☐ _____
Name of Retiree

Legal last name: _____ Legal first name: _____ Middle Initial (Optional): _____

Birth Date: _____

Sex:
☐ M ☐ F

Social Security Number: _____

Phone Number: _____

Alternate Phone Number: _____

Permanent Residence (Physical) Address (cannot be a PO Box):

City: _____

County: _____

State: _____

ZIP Code: _____

Mailing Address (only if different from your Permanent Residence Address):

Address: _____

City: _____

State: _____

ZIP Code: _____

Member Email Address: _____

Emergency Contact Name: _____

Phone Number: _____

Relationship to You: _____

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

OR

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare prescription drug plan.

Name (as it appears on your Medicare Card): _____

Medicare Number: _____

Effective Date: _____

HOSPITAL (Part A): _____

MEDICAL (Part B): _____

Signature: _____

Date: _____

Submit completed form to: OSU/A&M Benefits, 201 GAB, Stillwater, OK 74078; or email: osu-benefits@okstate.edu; or fax: 405-744-8345