



Plan Selection Form: Retiree Supplemental Medical

To be considered for coverage, you must:

- have Medicare Parts A and B
- have been employed by and retired from Oklahoma State University/A&M
- be age 65 or over or under age 65 with an eligible disability
- be a spouse of an employee who retired from OSU/A&M and were covered under the active employee Blue Cross and Blue Shield of Oklahoma Plan while your spouse was employed and/or retired

Group Information

Oklahoma State University (OSU)/A&M

Account number: 257207

Please circle your associated institution: CSC, LU, NEO, OPSU, OSU

Plan Selection

☐ Enhanced Plan 3 (F)

☐ Enhanced Plan 4 (HDF)

☐ Enhanced Plan 5 (G)

Applicant Information

Name (First)

(Middle)

(Last)

Home Address (No P. O. Boxes)

City

State

ZIP

Correspondence / Billing Address

City

State

ZIP

Primary Phone

Secondary Phone

Age

Date of Birth

/ /

Gender

☐ Male ☐ Female

Social Security Number

Email Address

Medicare Beneficiary Identifier

Please provide the Medicare Beneficiary Identifier from your red, white and blue Medicare Card. This number is required to process your plan selection.

Medicare Beneficiary Identifier _____

Part A Effective Date:

Part B Effective Date:

Medicare Reason (*circle one*): Age 65, Disability, or End Stage Renal Disease (ESRD)

Medicare Reason Effective Date:

Declination of Coverage

I am declining this coverage offered to me and my eligible dependents. 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.

Retiree:

Reason for Declining:

Eligible Dependent:

Reason for Declining:

Acknowledgments

1. I have both Medicare Parts A and B and meet the other qualification requirements.
2. I hereby declare that the statements and answers on this application are true and complete to the best of my knowledge and belief.

Signature

Applicant Signature

Date:

/ /

Please return your completed plan selection form via email, fax, or mail:

- Email: osu-benefits@okstate.edu
- Fax: 405-744-8345
- Mail:
OSU Benefits
201 N. GAB
Stillwater, OK 74078