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
  601 N. Willis
  PB# 8075
  Stillwater, OK 74078