OSU/A&M RETIREE ELECTION FORM

PERSONAL INFORMATION – Please Print

CWID or SSN: ___ ___ ___ ___ ___ ___ ___ ___ ___ Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Home Telephone: _____

Email: _____ Effective Date: _____

HEALTH PLAN – BlueCross BlueShield ☐KEEP ☐DROP

☐ BlueOptions ☐ BlueEdge High Deductible ☐ **Age 65 or older***

***Age 65 and over must sign up for Medicare A and B; then complete and submit enrollment applications for BCBS Supplemental and BlueRx plans to OSU Benefits, within 60-90 days prior to retirement.**

DENTAL PLAN – Delta Dental of Oklahoma ☐KEEP ☐DROP

☐ Low Plan ☐ High Plan ☐ Platinum Plan

VISION PLAN – Vision Service Plan (VSP) ☐KEEP ☐DROP

☐ Base Plan ☐ Buy-Up Plan

DEPENDENT INFORMATION

			KEEP	DROP
SPOUSE:	Name: _____	SSN: _____		
	Date of Birth: _____	Gender: M F	☐	☐ Health
			☐	☐ Dental
			☐	☐ Vision
CHILD:	Name: _____	SSN: _____		
	Date of Birth: _____	Gender: M F	☐	☐ Health
			☐	☐ Dental
			☐	☐ Vision
CHILD:	Name: _____	SSN: _____		
	Date of Birth: _____	Gender: M F	☐	☐ Health
			☐	☐ Dental
			☐	☐ Vision

IMPORTANT INSTRUCTIONS: To elect under age 65 retiree coverage, complete this Election Form and return it to OSU Benefits. The form needs to be received by OSU Benefits by the end of the month in which you retire. If you do not submit this form, you will lose your right to elect retiree coverage. Also, you will not be eligible for the OTRS health credit if applicable.

I understand that Chard Snyder will bill me and my monthly premiums are due from the effective date of retiree insurance and must be paid by the 1st of the month. If payment is not received by the end of the month, coverage will be cancelled.

SIGNATURE: _____ **DATE:** _____

For questions regarding retiree insurance, please contact OSU Benefits at 405-744-5449, osu-benefits@okstate.edu. Fax: 405-744-8345 or Mail completed form to: Oklahoma State University, Attn: Benefits, 601 N. Willis, PMB 8075, Stillwater, OK 74078