



Cameron University Retiree Insurance Election Form

R7 09/25

Date of Retirement _____ Retired Under 65 ☐ Retired Over 65 ☐

Last Name _____ First Name _____ MI _____ SS # _____

Address (PO BOX is not allowed) _____ City _____ State _____ Zip _____

Birthdate _____ ☐ Male ☐ Female ☐ Married ☐ Single _____
Phone # _____

Retiree Under 65:

Select a Medical Plan:

☐ BCBS OK Option (retiree-paid)

☐ Drop Coverage – I understand that I will lose my TRS subsidy and will not be able to enroll at a later date.

OR:

Retiree Over 65/Medicare Eligible:

Dependents must be enrolled with same option employee selects

Retiree Medicare ID# _____ Spouse Medicare ID# _____

☐ Humana Medicare Advantage Prescription Drug PPO Plan (retiree-paid)

☐ No Coverage – I understand that I will lose my TRS subsidy and will not be able to enroll at a later date.

BCBS Dental (retiree-paid) ☐ Basic Option ☐ Alternate Option ☐ No coverage

VSP Vision Plan (retiree-paid) ☐ Standard Option ☐ Premium Option ☐ No coverage

Dependents/Options: Additions or Deletions

	Add	Drop	Name	Relationship	Birthdate	SSN	M/F
Health							
Dental							
Vision							
Health							
Dental							
Vision							
Health							
Dental							
Vision							

Retiree Signature _____

Date _____