

# Tulsa Community College Over 65 Enrollment Form

**Return Form to:**  
 Tulsa Community College  
 Human Resources  
 909 South Boston Ave  
 Tulsa, OK 74119



**Member Information:** Please complete the information below.

Retiree Social Security Number	Last Name, First Name, M.I.	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Gender
Permanent Residence Street Address	City, State ZIP Code	Home Phone	Date of Birth MM/DD/YYYY

**Medical Plan Options** Please check the box indicating if you will keep (circle plan election if wanting to change current election) or drop coverage.

**Aetna Medicare Plan Options (Monthly Premiums)**

<input type="checkbox"/> Keep <input type="checkbox"/> Drop	RETIREE ELECTION	SPOUSE ELECTION
Aetna Medicare Plan C04 HIGH PLAN	\$438.86 monthly	\$438.86 monthly
Aetna Medicare Plan S02 LOW PLAN	\$347.97 monthly	\$347.97 monthly
Aetna Medicare Plan HIGH SCRIPT PLAN	\$210.66 monthly	\$210.66 monthly

**Medicare Information - You must have Medicare Part A and Part B to join a Medicare Advantage Plan:**

Use your Medicare card to complete this section.  
 ⇒ Fill in these blanks so they match your red, white and blue Medicare Card OR  
 ⇒ Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

RETIREE MEDICARE NUMBER	SPOUSE MEDICARE NUMBER
NAME _____ SEX _____	NAME _____ SEX _____
MEDICARE CLAIM NUMBER _____	MEDICARE CLAIM NUMBER _____
Is entitled to: EFFECTIVE DATE:	Is entitled to: EFFECTIVE DATE:
Hospital (Part A) _____/_____/_____	Hospital (Part A) _____/_____/_____
Hospital (Part B) _____/_____/_____	Hospital (Part B) _____/_____/_____

**Dental Plan Options** Please check the box indicating if you will keep (circle plan election if wanting to change current election) or drop coverage.

BCBS OK Dental Plans (Monthly Premiums)				
<input type="checkbox"/> Keep <input type="checkbox"/> Drop	Retiree Only	Retiree + Spouse	Retiree + Child(ren)	Retiree + Family
Blue Cross Blue Shield Dental LOW PLAN OPTION	\$19.38 monthly	\$38.78 monthly	\$51.38 monthly	\$78.12 monthly
Blue Cross Blue Shield Dental HIGH PLAN OPTION	\$38.46 monthly	\$76.84 monthly	\$100.30 monthly	\$152.96 monthly

Complete Back Portion

**Vision Plan Options** Please check the box indicating if you will keep/add (circle plan election if wanting to change/add current election) or drop coverage.

<b>MetLife Plans (Monthly Premiums)</b>				
<input type="checkbox"/> Keep/Add <input type="checkbox"/> Drop	<b>Retiree Only</b>	<b>Retiree + Spouse</b>	<b>Retiree + Child(ren)</b>	<b>Retiree + Family</b>
<input type="checkbox"/> MetLife Vision LOW PLAN OPTION	\$ 8.06 monthly	\$16.14 monthly	\$17.24 monthly	\$27.56 monthly
<input type="checkbox"/> MetLife Vision HIGH PLAN OPTION	\$13.62 monthly	\$27.28 monthly	\$29.16 monthly	\$46.60 monthly

**Dependent Information—Please list dependents including your spouse if electing to keep/add/drop coverage.**

Family Info	Last Name, First Name, M.I.	Relationship to Retiree	Sex M/F	Birth date MM/DD/YYYY	Social Security Number	Circle Coverage Elected for Each		
						Health	Dental	Vision
SP						Keep/Drop	Keep/Drop	Keep/Add/Drop
C1						Keep/Drop	Keep/Drop	Keep/Add/Drop
C2						Keep/Drop	Keep/Drop	Keep/Add/Drop
C3						Keep/Drop	Keep/Drop	Keep/Add/Drop

**Voluntary Life** Please check the box indicating the plan/coverages you are electing.

**Retiree:** Current life insurance?  Keep  Drop  Reduce \$ \_\_\_\_\_ (\$1,000 Increments, maximum \$200,000)

**Beneficiary Designation - Voluntary Life**

	Last name, First name, M.I.	Date of Birth	SSN	Relationship	Mailing Address	Phone Number	Percentage
Primary							
Primary							
Contingent							
Contingent							

**I acknowledge that these elections will be in force from January 1, 2024 through December 31, 2024, unless I have a qualifying event change and notify Tulsa Community College within 30 days from the date of the event.** I understand I must abide by the provision of each plan as contained in the plan benefit guides. By signing below, I represent that all the information I have listed is true and complete to the best of my knowledge and belief. I acknowledge that any material misstatements or omissions of information that are made on this application may be the basis for later withdrawal of insurance coverage or denial of benefits incurred during my or my dependent's coverage.

**WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.**

Retiree Signature (Required)	Retiree E-mail Address	Date (MM/DD/YYYY)
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Every effort has been made to ensure that the information in this statement is accurate; however no warranty of complete accuracy is made. This report does not in any way constitute a contract of employment. Tulsa Community College reserves the right to amend pay and benefits at any time without notice. If you feel an error has been made or have any questions, please contact Human Resources.