



Enrollment, Change and Declination Form



ELIGIBILITY:	Are you an active employee and making monthly contributions to TRS? <input type="checkbox"/> Yes <input type="checkbox"/> No	(If no to both, you are not eligible for TRS ActiveCare coverage)
	If no, are you regularly scheduled to work 10 or more hours per week? <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 1: ENROLLMENT/CHANGE TRANSACTION TYPE

<input type="checkbox"/> Annual Enrollment <input type="checkbox"/> New Employee <input type="checkbox"/> Add Dependent <input type="checkbox"/> Special Enrollment				For District Use Only
<input type="checkbox"/> For New Employee (check one): <input type="checkbox"/> Effective on Actively at Work <input type="checkbox"/> Effective 1 st day of month following				
Special Enrollment Event Date: ___/___/___		<input type="checkbox"/> Marriage <input type="checkbox"/> Court Order <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Other: _____		TRS District # Actively at Work Date: Effective/Change Date:
Change Only: <input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Plan/Coverage	Decline Coverage: <input type="checkbox"/> Yes (Complete Section 6) <input type="checkbox"/> N/A Effective Date of Change/Cancel ___/___/___	Cancel Employee <input type="checkbox"/> Death <input type="checkbox"/> Loss of Eligibility <input type="checkbox"/> Retirement/Terminated <input type="checkbox"/> Non-Payment <input type="checkbox"/> Other: _____	Cancel Dependent <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Loss of Eligibility <input type="checkbox"/> Dropped Coverage <input type="checkbox"/> Other: _____	Employer Approval: _____ Were you covered by another district? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, which: _____

SECTION 2: EMPLOYEE INFORMATION

Last Name:		First Name:		MI:	Social Security #:	
Mailing Address:			City:	State:	Zip:	
Residence Address:			City:	State:	Zip:	
Home Phone Number:		Cell Phone Number:		Email:		
Date of Birth:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish		Ethnicity:		
Do you have a disability affecting your ability to communicate or read? <input type="checkbox"/> Yes (Please complete Section 8) <input type="checkbox"/> No						
Is the Employee Covered By Other Insurance? <input type="checkbox"/> Yes Carrier/Plan: _____ <input type="checkbox"/> No						
Is the Employee Covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part C <input type="checkbox"/> Part D Effective: _____ <input type="checkbox"/> No						
Reason for Medicare Coverage: <input type="checkbox"/> Entitlement Age <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal Disease (ESRD)						

SECTION 3: COVERAGE SELECTION (Please select a Plan of Coverage – Plan or HMO - and Coverage Type)

Plan Selection:	<input type="checkbox"/> ActiveCare 1-HD	<input type="checkbox"/> ActiveCare Select	<input type="checkbox"/> ActiveCare Kelsey Select	<input type="checkbox"/> ActiveCare 2
HMO Selection:	<input type="checkbox"/> FirstCare Health Plans	<input type="checkbox"/> Scott & White Health Plan	<input type="checkbox"/> Blue Essentials Access Plan (formerly Allegian Health Plans)	
Coverage Type Selected:	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Employee + Child(ren)	<input type="checkbox"/> Employee + Family

SECTION 4: DEPENDENT INFORMATION (Use additional form for additional dependents)

SPOUSE Last Name:		First Name:		MI:
Street Address:				<input type="checkbox"/> Same as Employee
City:		State:	Zip:	Phone Number:
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:		Social Security #:	
Other Insurance: <input type="checkbox"/> Yes. Carrier/Plan <input type="checkbox"/> No <input type="checkbox"/> Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part C <input type="checkbox"/> Part D				
CHILD Last Name:		First Name:		MI:
<input type="checkbox"/> Natural/Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Disabled <input type="checkbox"/> Other				
Street Address:				<input type="checkbox"/> Same as Employee
City:		State:	Zip Code:	Phone Number:
Date of Birth:	Social Security #:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Other Insurance: <input type="checkbox"/> Yes. Carrier/Plan <input type="checkbox"/> No <input type="checkbox"/> Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part C <input type="checkbox"/> Part D				
CHILD Last Name:		First Name:		MI:
<input type="checkbox"/> Natural/Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Disabled <input type="checkbox"/> Other				
Street Address:				<input type="checkbox"/> Same as Employee
City:		State:	Zip Code:	Phone Number:
Date of Birth:	Social Security #:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Other Insurance: <input type="checkbox"/> Yes. Carrier/Plan <input type="checkbox"/> No <input type="checkbox"/> Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part C <input type="checkbox"/> Part D				

CHILD Last Name:		First Name:			MI:
<input type="checkbox"/> Natural/Adopted	<input type="checkbox"/> Stepchild	<input type="checkbox"/> Foster Child	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Disabled <input type="checkbox"/> Other
Street Address:					<input type="checkbox"/> Same as Employee
City:		State:	Zip Code:	Phone Number:	
Date of Birth:	Social Security #:			Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Other Insurance: <input type="checkbox"/> Yes. Carrier/Plan		<input type="checkbox"/> No <input type="checkbox"/> Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part C <input type="checkbox"/> Part D			

CHILD Last Name:		First Name:			MI:
<input type="checkbox"/> Natural/Adopted	<input type="checkbox"/> Stepchild	<input type="checkbox"/> Foster Child	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Disabled <input type="checkbox"/> Other
Street Address:					<input type="checkbox"/> Same as Employee
City:		State:	Zip Code:	Phone Number:	
Date of Birth:	Social Security #:			Sex: <input type="checkbox"/> M <input type="checkbox"/> F:	
Other Insurance: <input type="checkbox"/> Yes. Carrier/Plan		<input type="checkbox"/> No <input type="checkbox"/> Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part C <input type="checkbox"/> Part D			

SECTION 5: DISABLED DEPENDENTS OVER AGE 26 Request for Continuation of Coverage for Handicapped Child form and Attending Physician's Statement

Please note that a Request for Continuation of Coverage for Handicapped Child form and Attending Physician's Statement are required for coverage of a disabled child over age 26. See your Benefits Administrator for the forms, which must be completed in full and submitted to your Benefits Administrator.

SECTION 6: DECLINATION OF COVERAGE

This is to certify that the available coverage has been explained to me. I have been given the opportunity to apply for the coverage available to me and my dependents and have voluntarily elected to decline the coverage as elected below.

Name:	SSN:	<input type="checkbox"/> Employee	Reason:	<input type="checkbox"/> Other Coverage	<input type="checkbox"/> Other:
Gender: F M	Date of Birth:	Address:	same as employee		
Name:	SSN:	<input type="checkbox"/> Spouse	Reason:	<input type="checkbox"/> Other Coverage	<input type="checkbox"/> Other:
Gender: F M	Date of Birth:	Address:	same as employee		
Name:	SSN:	<input type="checkbox"/> Child	Reason:	<input type="checkbox"/> Other Coverage	<input type="checkbox"/> Other:
Gender: F M	Date of Birth:	Address:	same as employee		
Name:	SSN:	<input type="checkbox"/> Child	Reason:	<input type="checkbox"/> Other Coverage	<input type="checkbox"/> Other:
Gender: F M	Date of Birth:	Address:	same as employee		
Name:	SSN:	<input type="checkbox"/> Child	Reason:	<input type="checkbox"/> Other Coverage	<input type="checkbox"/> Other:
Gender: F M	Date of Birth:	Address:	same as employee		
Name:	SSN:	<input type="checkbox"/> Child	Reason:	<input type="checkbox"/> Other Coverage	<input type="checkbox"/> Other:
Gender: F M	Date of Birth:	Address:	same as employee		

SECTION 7: COVERAGE CONDITIONS

- I am employed by the Employer named in this Enrollment Application and Change Form. I am eligible to participate in the coverage(s) offered by the TRS-ActiveCare program which is administered by Aetna, with HMO benefits provided by SHA, L.L.C. dba FirstCare Health Plan, Scott and White Health Plan, and Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation Health Plans. On behalf of myself and any dependents listed on their Enrollment Application and Change Form, I apply for those coverage(s) for which I am eligible.
 - If I am enrolling a grandchild in Section 4, I certify that my household is the grandchild's primary residence and the grandchild is my dependent for federal income tax purposes for the reporting year in which coverage of the grandchild is in effect.
 - If I am enrolling a child as an "other Child" in Section 4, I certify that my household is the child's primary residence, that I provide at least 50% of the child support, that neither of the children's natural parents reside in my household, and that I have the legal right to make decisions regarding the child's medical care.
- Only those coverage(s) and amount for which I am eligible will be available to me. I understand that if this Enrollment Application and Change Form is accepted, the coverage(s) will become effective in accordance with the provisions or the TRS-ActiveCare program.
- I understand that by enrolling for coverage with Employer named in the Enrollment Application and Change Form that any TRS-ActiveCare coverage I previously elected under another TRS-ActiveCare participating district/entity will be terminated under TRS Rules.
- I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s). I agree that my Employer acts as my agent. All notices given to my Employer are binding upon me. I also agree that my participation in the coverage(s) is subject to any future amendments.
- I understand that by declining TRS-ActiveCare coverage now or by terminating TRS-ActiveCare coverage during the plan year, I am not eligible to re-enroll in TRS-ActiveCare until the next plan year, unless I experience a special enrollment event.
- I state that the information given on the Enrollment Application and Change Form is true and correct. I understand and agree that any incorrect statements material to the risk and knowingly made by me will invalidate my coverage(s).

Applicant Signature: _____ Date: _____

SECTION 8: SPECIAL NOTES REGARDING MY ENROLLMENT (Please indicate any special information regarding my enrollment for Aetna, Caremark or my selected HMO)