

Enrollment, Change and Declination Form

Eligibility:

Are you an active employee and making monthly contributions to TRS? Yes No
 If no, are you regularly scheduled to work 10 or more hours per week? Yes No

*If no to both, you are not eligible for TRS ActiveCare coverage.

Section 1: Enrollment/Change Transaction Type		
*Carefully review Options 1-3 before making any selections.		
Option 1: Enrollments		
<input type="checkbox"/> Annual Enrollment <input type="checkbox"/> Add Dependent <input type="checkbox"/> New Employee* <input type="checkbox"/> Special Enrollment**	*Choose effective date if selecting New Employee: <input type="checkbox"/> Effective on actively at work <input type="checkbox"/> Effective 1 st day of the following month	For District Use Only TRS District #: Actively at Work Date: / / Effective/Change Date: / / Employer Approval:
Choose a Life Event type if selecting Special Enrollment: <input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Loss of Coverage* <input type="checkbox"/> Court Order <input type="checkbox"/> Other: _____	***If you selected Loss of Coverage please specify: 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: _____
Date of Life Event: ____ / ____ / ____		
Were you previously covered by a different district? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, District Name: _____		
Option 2: Changes	Option 3: Decline Coverage	
<input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Plan/Coverage Effective Date of Change: ____ / ____ / ____	<input type="checkbox"/> Yes <input type="checkbox"/> N/A *If selecting yes, must complete Section 7	
Section 2: Employee Information		
Last Name: _____ First Name: _____ MI: _____ SSN: _____ - -		
Address: _____ City: _____ State: _____ Zip: _____		
Alternate Address: _____ City: _____ State: _____ Zip: _____		
Date of Birth: ____ / ____ / ____ Work Phone: - - - - Work Email: _____		
Sex: <input type="checkbox"/> M <input type="checkbox"/> F Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish Tobacco User: <input type="checkbox"/> Yes <input type="checkbox"/> No Race/Ethnicity: _____		
Are you covered by other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Reason for Medicare Coverage:	Medicare Coverage Type:	
<input type="checkbox"/> Entitlement Age	<input type="checkbox"/> Medicare A and D Primary	<input type="checkbox"/> Medicare A and B Primary
<input type="checkbox"/> Disability	<input type="checkbox"/> Medicare A, B and D Primary	<input type="checkbox"/> Medicare B Primary
<input type="checkbox"/> End State Renal Disease (ESRD)	<input type="checkbox"/> Medicare B and D Primary	<input type="checkbox"/> Medicare Unknown
	<input type="checkbox"/> Medicare D Primary	<input type="checkbox"/> Other Coverage
	<input type="checkbox"/> Medicare A Primary	
Section 3: Coverage Selection		
Plan Selection: <input type="checkbox"/> TRS-ActiveCare Primary <input type="checkbox"/> TRS-ActiveCare HD <input type="checkbox"/> TRS-ActiveCare Primary+ <input type="checkbox"/> TRS-ActiveCare 2	HMO Selection: <input type="checkbox"/> South Texas Blue Essentials Plan* <input type="checkbox"/> Central and North Texas Scott & White Health Plan* <input type="checkbox"/> West Texas Blue Essentials Plan*	Coverage Tier: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family
*plan eligibility is based on home or work location		

Section 4: Primary Care Provider (PCP)

To elect coverage in the TRS-ActiveCare Primary, TRS-ActiveCare Primary+ or Blue Essentials HMO plans you must choose a Primary Care Provider (PCP) for yourself and your dependents. If you already have a PCP, you can enter the information in the box below.

If you are enrolling in TRS-ActiveCare Primary or TRS-ActiveCare Primary+, you can find your PCP ID number by going to www.bcbstx.com/trsactivecare/doctors-and-hospitals and clicking on the plan you're enrolling in. You will be taken to the Provider Finder search tool for that plan. Simply type in your desired PCP and input the PCP ID number found under Provider Highlights.

If you do not have a PCP, you can select one by following the link above to the Provider Finder search tool, clicking on the Browse by Category drop down, choose Medical Care and then Primary Care. You'll be able to select a PCP based off specialty and location.

If you are enrolling in Blue Essentials HMO, you can find a new PCP or your current PCP's ID number by going to www.bcbstx.com/trshmo/doctors-and-hospitals and following the instructions listed above.

If you enroll in these plans and do not choose a PCP one will be chosen for you and the provider number will be on your new ID cards for you and all dependents listed below. If you have questions about the TRS-ActiveCare Primary or TRS-ActiveCare Primary+ plans, please call your Personal Health Guide at (866) 355-5999.

Blue Essentials HMO participants can call Blue Essentials customer service line at (888)-378-1633.

Primary Care Provider name:

PCP ID #:

Section 5: Dependent Information (Use additional form for more dependents)

SPOUSE Last Name: _____ First Name: _____ MI: _____
Address: _____ Same as Employee
City: _____ State: _____ Zip: _____
Phone Number: _____ - _____ - _____ Sex: M F Date of Birth: ____/____/____ SSN: _____ - _____ - _____
Primary Care Physician Name: _____
PCP ID #: _____
Are you covered by other insurance? Yes No If yes, Carrier/Plan: _____
Tobacco User: Yes No
If Medicare, select a coverage type:
 Medicare A and D Primary Medicare D Primary Medicare B Primary
 Medicare A, B and D Primary Medicare A Primary Medicare Unknown
 Medicare B and D Primary Medicare A and B Primary Other Coverage

CHILD Last Name: _____ First Name: _____ MI: _____
 Child Grandchild Disabled Other Tobacco user (*required for children 18 and older)
Address: _____ Same as Employee
City: _____ State: _____ Zip: _____
Phone Number: _____ - _____ - _____ Sex: M F Date of Birth: ____/____/____ SSN: _____ - _____ - _____
Primary Care Physician Name: _____
PCP ID #: _____
Are you covered by other insurance? Yes No If yes, Carrier/Plan: _____
If Medicare, select a coverage type:
 Medicare A and D Primary Medicare D Primary Medicare B Primary
 Medicare A, B and D Primary Medicare A Primary Medicare Unknown
 Medicare B and D Primary Medicare A and B Primary Other Coverage

CHILD Last Name: _____ First Name: _____ MI: _____
 Child Grandchild Disabled Other Tobacco user (*required for children 18 and older)
Address: _____ Same as Employee
City: _____ State: _____ Zip: _____
Phone Number: _____ - _____ - _____ Sex: M F Date of Birth: ____/____/____ SSN: _____ - _____ - _____
Primary Care Physician Name: _____
PCP ID #: _____
Are you covered by other insurance? Yes No If yes, Carrier/Plan: _____
If Medicare, select a coverage type:
 Medicare A and D Primary Medicare D Primary Medicare B Primary
 Medicare A, B and D Primary Medicare A Primary Medicare Unknown
 Medicare B and D Primary Medicare A and B Primary Other Coverage

CHILD Last Name: _____ First Name: _____ MI: _____
 Child Grandchild Disabled Other Tobacco user (*required for children 18 and older)
Address: _____ Same as Employee
City: _____ State: _____ Zip: _____
Phone Number: _____ - _____ - _____ Sex: M F Date of Birth: ____/____/____ SSN: _____ - _____ - _____
Primary Care Physician Name: _____
PCP ID #: _____
Are you covered by other insurance? Yes No If yes, Carrier/Plan: _____
If Medicare, select a coverage type:
 Medicare A and D Primary Medicare D Primary Medicare B Primary
 Medicare A, B and D Primary Medicare A Primary Medicare Unknown
 Medicare B and D Primary Medicare A and B Primary Other Coverage

CHILD Last Name: _____ First Name: _____ MI: _____
 Child Grandchild Disabled Other Tobacco user (*required for children 18 and older)
 Address: _____ Same as Employee
 City: _____ State: _____ Zip: _____
 Phone Number: _____ - _____ - _____ Sex: M F Date of Birth: ____ / ____ / ____ SSN: ____ - ____ - ____
 Primary Care Physician Name: _____
 PCP ID #: _____
 Are you covered by other insurance? Yes No If yes, Carrier/Plan: _____
 If Medicare, select a coverage type:
 Medicare A and D Primary Medicare D Primary Medicare B Primary
 Medicare A, B and D Primary Medicare A Primary Medicare Unknown
 Medicare B and D Primary Medicare A and B Primary Other Coverage

Section 6: Disabled Dependents Over Age 26

Request for Dependent Child Statement of Disability
 * Please note that a Dependent Child Statement of Disability is required for coverage of a disabled child over age 26 and must be **submitted within 31 days** of the child's 26th birthday. See your Benefits Administrator for the form, which must be completed in full and submitted to your Benefits Administrator.

Section 7: 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 Gender: <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth: ____ / ____ / ____ <input type="checkbox"/> Other Coverage: _____ Address: _____
Name: _____ SSN: _____ - - - - <input type="checkbox"/> Spouse Gender: <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth: ____ / ____ / ____ <input type="checkbox"/> Other Coverage: _____ Address: _____ <input type="checkbox"/> Same as Employee
Name: _____ SSN: _____ - - - - <input type="checkbox"/> Child Gender: <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth: ____ / ____ / ____ <input type="checkbox"/> Other Coverage: _____ Address: _____ <input type="checkbox"/> Same as Employee
Name: _____ SSN: _____ - - - - <input type="checkbox"/> Child Gender: <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth: ____ / ____ / ____ <input type="checkbox"/> Other Coverage: _____ Address: _____ <input type="checkbox"/> Same as Employee
Name: _____ SSN: _____ - - - - <input type="checkbox"/> Child Gender: <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth: ____ / ____ / ____ <input type="checkbox"/> Other Coverage: _____ Address: _____ <input type="checkbox"/> Same as Employee
Name: _____ SSN: _____ - - - - <input type="checkbox"/> Child Gender: <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth: ____ / ____ / ____ <input type="checkbox"/> Other Coverage: _____ Address: _____ <input type="checkbox"/> Same as Employee

Section 8: Coverage Conditions

I am eligible to participate in the coverage(s) offered by the TRS-ActiveCare program which is administered by Blue Cross and Blue Shield of Texas (BCBSTX), a Division of Health Care Service Corporation, with HMO benefits provided by Baylor, Scott and White Health Plan and Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation Plans. On behalf of myself and any dependents listed, I apply for those coverage(s) for which I am eligible.

- If I am enrolling a grandchild, 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 5, 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 resides 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 my coverage requests are accepted, the coverage(s) will become effective in accordance with the provisions or the TRS-ActiveCare program.

I understand that by enrolling for coverage 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 provided in this enrollment 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: ____ / ____ / ____