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

☐ Annual Enrollment
☐ Add Dependent
☐ New Employee*
☐ Special Enrollment**

*Choose effective date if selecting **New Employee**:
☐ Effective on actively at work
☐ Effective 1st day of the following month

For District Use Only
TRS District #: 1433
Actively at Work Date: / /
Effective/Change Date: / /
Employer Approval:

Choose a Life Event type if selecting **Special Enrollment:
☐ Marriage
☐ Birth/Adoption
☐ Loss of Coverage***
☐ Court Order
☐ Other:_____

***If you selected **Loss of Coverage** please specify:

Cancel Employee:
☐ Death
☐ Loss of Eligibility
☐ Retirement/Terminated
☐ Non-Payment
☐ Other:_____

Cancel Dependent:
☐ Divorce
☐ Death
☐ Loss of Eligibility
☐ Dropped Coverage
☐ Other:_____

Date of Life Event:____/____/_____

Were you previously covered by a different district? ☐ Yes ☐ No

If yes, District Name: _____

Option 2: Changes

☐ Name
☐ Address
☐ Plan/Coverage

Effective Date of Change:____/____/_____

Option 3: Decline Coverage

☐ Yes
☐ 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: ☐ M ☐ F Language: ☐ English ☐ Spanish Tobacco User: ☐ Yes ☐ No Race/Ethnicity: _____

Are you covered by other insurance? ☐ Yes ☐ No

Are you covered by Medicare? ☐ Yes ☐ No

Reason for Medicare Coverage:
☐ Entitlement Age
☐ Disability
☐ End State Renal Disease (ESRD)

Medicare Coverage Type:
☐ Medicare A and D Primary
☐ Medicare A, B and D Primary
☐ Medicare B and D Primary
☐ Medicare D Primary
☐ Medicare A Primary
☐ Medicare A and B Primary
☐ Medicare B Primary
☐ Medicare Unknown
☐ Other Coverage

Section 3: Coverage Selection

Plan Selection:
☐ TRS-ActiveCare Primary
☐ TRS-ActiveCare HD
☐ TRS-ActiveCare Primary+
☐ TRS-ActiveCare 2

OR

HMO Selection:
☐ South Texas Blue Essentials Plan*
☐ Central and North Texas Scott & White Health Plan*
☐ West Texas Blue Essentials Plan*

Coverage Tier:
☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ 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:________-_______-________ ☐ Employee
Gender: ☐ M ☐ F Date of Birth:_______/_____/________ ☐ Other Coverage:________________
Address: ________________

Name:________________ SSN:________-_______-________ ☐ Spouse
Gender: ☐ M ☐ F Date of Birth:_______/_____/________ ☐ Other Coverage:________________
Address:________________ ☐ Same as Employee

Name:________________ SSN:________-_______-________ ☐ Child
Gender: ☐ M ☐ F Date of Birth:_______/_____/________ ☐ Other Coverage:________________
Address:________________ ☐ Same as Employee

Name:________________ SSN:________-_______-________ ☐ Child
Gender: ☐ M ☐ F Date of Birth:_______/_____/________ ☐ Other Coverage:________________
Address:________________ ☐ Same as Employee

Name:________________ SSN:_-________-____________ ☐ Child
Gender: ☐ M ☐ F Date of Birth:_______/_____/________ ☐ Other Coverage:________________
Address:________________ ☐ Same as Employee

Name:________________ SSN:_-________-_________ ☐ Child
Gender: ☐ M ☐ F Date of Birth:_______/_____/________ ☐ Other Coverage: ________________
Address:________________ ☐ 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 Health, 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 Health 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:____/____/____

Spring Branch Independent School District

Benefits Department
955 Campbell Road, Houston, Texas 77024
(713) 464-1511

Authorization for Direct Payment Automatic Bill Payment
Health Insurance Premium

I (we) authorize Spring Branch ISD to initiate variable entries to my (our) account described below:

Checking Account #: _____ Savings Account #: _____

Routing Number: _____

Financial Institution's Name: _____

Financial Institution's Address: _____

_____

Attach a voided check to confirm the account and routing numbers. This authority is to remain in full force and effect through August 31, 2021 to provide for payment of health insurance premium per the enrollment selections made by me (us) during my enrollment period for the 2020-2021 insurance plan year. This authority may be terminated prior to August 31, 2021 if Spring Branch ISD receives written notification of my (our) benefits termination due to the occurrence of a qualifying event as defined by federal law and in such time and manner as to afford Spring Branch ISD a reasonable opportunity to act on it. If a direct payment is rejected by your bank due to your account's insufficient funds, the district may require future payments to be made in person.

Signature: _____

Full Name: _____

Address: _____

City & Zip Code: _____

Phone Number: _____

Email Address: _____

Date: _____

(Optional for Joint Account)

Signature: _____

Full Name: _____

Date: _____

FOR SBISD USE ONLY:

Benefits Representative: _____

Date Benefits Begin: _____

Insurance Election: _____

Monthly Premium Amount: $_____