Waiver of Group Health Benefits

Employee Name _____

Job Title _____

Employee Number (ID, Social Security, etc.) _____

For the plan year effective 9/1/2021
I am waiving coverage for:

☐ Myself

☐ Spouse/Domestic Partner

☐ Dependents(s):

If selecting Dependent(s), please list their name(s): _____

I am waiving coverage due to:

☐ My preference not to have coverage

☐ Coverage under my spouse's/domestic partner's plan

☐ Other coverage

This other coverage is:

☐ Employer-sponsored Group Plan ☐ Individual policy ☐Medicare ☐ COBRA ☐TRICARE ☐ Medicaid

☐ SHOP Plan ☐Exchange Plan **with** subsidiary ☐Exchange Plan **without** subsidiary ☐Miscellaneous

Special Enrollment Notice and Certification – *Please review and sign below if you wish to waive coverage*

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that, if I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

I understand that the offer of these plans by employer meets both the 60% Minimum Value and is deemed affordable. This means that I will not be eligible to receive a subsidy for a plan in the Exchange. I may still purchase a plan from the Exchange without a subsidy and I may be eligible for MediCal/MedicAid.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that in order to request special enrollment or obtain more information, I should contact my group administrator.

Employee Signature _____ Date _____

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 #:
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:____/____/____