Enrollment Application and Change Form

TRS ActiveCare
TEACHER RETIREMENT SYSTEM OF TEXAS

Group Number 085000 www.trs.state.tx.us/trs-activecare

Please print in blue or black ink.

ELIGIBILITY Are you actively employed 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 EVENTS Check all that apply

District/Employer Name

☐ New Enrollee ☐ Add Dependent
Are you applying as a result of:
Annual Enrollment? ☐ Yes ☐ No
Special Enrollment Event? ☐ Yes ☐ No
If yes, indicate event date: MM DD YYYY
Event: ☐ Marriage ☐ Birth or Adoption ☐ Court Order ☐ Loss of Other Coverage ☐ Other, Explain:

If you are a new hire, when do you want coverage to begin?
☐ Actively-at-work date
☐ First of the month following the actively-at-work date

☐ Cancel Enrollee ☐ Cancel Dependent
List names of those canceling in Section 5
Event: ☐ Divorce* ☐ Death* ☐ Loss of Eligibility
☐ Terminated Employment or Retirement
☐ Non-Payment of Premium
☐ Leave of Absence Period Expired
☐ Dropped Coverage (Employee Request)
☐ Other Explain:
Indicate event date: MM DD YYYY

☐ Change
☐ Plan/Coverage
☐ Address
☐ Name

☐ Declining Coverage (Complete Sections 2 & 9)

For Employer Use Only
TRS Reporting Number
Employee's Actively-at-Work Date MM DD YYYY
Effective Date of Coverage MM DD YYYY
Employer Verification Signature

SECTION 2 — PLEASE TELL US ABOUT YOURSELF Complete even if declining coverage

☐ Male ☐ Female ☐ Married ☐ Single | Last Name | First Name | Middle Initial

Birth Date MM DD YYYY | Social Security Number ___-___-___ | Work Phone Number ( ) | Home Phone Number ( )

Mailing Address | City | State | ZIP

Home Email Address

Complete only if you are applying for HMO Coverage

Primary Language: | Do you have a disability affecting your ability to communicate or read: ☐ Yes ☐ No | Describe special communication materials needed: | PCP Number for HMO:

FEMALE enrollees: You have the right to designate an OB/GYN physician to whom you have access without first obtaining a referral from your Primary Care Physician. You are not required to designate an OB/GYN; you may elect to receive your OB/GYN services from your PCP. If you wish to designate an OB/GYN physician, please list the provider number. | OB/GYN Number for HMO:

SECTION 3 — MEDICARE INFORMATION Complete if you or any dependents are covered by Medicare (Attach another application if more space is needed)

Name of person covered: | **HIC# (from ID card):**

☐ Medicare Part A (hospital) Start Date: MM DD YYYY End Date: MM DD YYYY

☐ Medicare Part B (medical) Start Date: MM DD YYYY End Date: MM DD YYYY

☐ Medicare Part C ☐ w/drugs OR ☐ without drugs Start Date: MM DD YYYY End Date: MM DD YYYY

☐ Medicare Part D (prescription drugs) Start Date: MM DD YYYY End Date: MM DD YYYY

Check reason for Medicare eligibility: ☐ Entitled age ☐ Entitled disability ☐ End-stage renal disease ☐ Disability and current renal disease

SECTION 4 — SELECT YOUR PLAN AND COVERAGE CATEGORY

Health Benefits Plan (Check one)

PPO: ☐ **ActiveCare 1-HD** ☐ **ActiveCare 1** (discontinued effective 9/1/2013) ☐ **ActiveCare 2** ☐ **ActiveCare 3**

HMO: ☐ **FirstCare** ☐ **Scott & White Health Plan** ☐ **Valley Baptist Health Plans**

Coverage Category (Check one)
☐ **Employee Only**
☐ **Employee and Spouse**
☐ **Employee and Child(ren)**
☐ **Employee and Family**

SECTION 5 — DEPENDENT COVERAGE Complete to apply for or make changes to dependent coverage

Spouse ☐ Add ☐ Drop ☐ Male ☐ Female | Last Name | First Name | Middle Initial | PCP Number for HMO:
Social Security Number | Birth Date MM DD YYYY | Mailing Address, if different | City | State | ZIP

Child ☐ Add ☐ Drop ☐ Male ☐ Female | Last Name | First Name | Middle Initial | PCP Number for HMO:
Social Security Number | Birth Date MM DD YYYY | Mailing Address, if different | City | State | ZIP
Indicate child's relationship to employee: ☐ Natural/adopted child ☐ Stepchild ☐ Foster child ☐ Legal guardianship ☐ Grandchild** ☐ Other child**

Child ☐ Add ☐ Drop ☐ Male ☐ Female | Last Name | First Name | Middle Initial | PCP Number for HMO:
Social Security Number | Birth Date MM DD YYYY | Mailing Address, if different | City | State | ZIP
Indicate child's relationship to employee: ☐ Natural/adopted child ☐ Stepchild ☐ Foster child ☐ Legal guardianship ☐ Grandchild** ☐ Other child**

* HMO enrollees may be eligible for state continuation coverage. See your Evidence of Coverage for more information.
** Must meet eligibility criteria specified in the first bullet under Coverage Conditions in Section 10.

If additional space for dependents is needed, see reverse side.

SECTION 5 — DEPENDENT COVERAGE (continued) Complete to apply for or make changes to dependent coverage

Child ❑ Add ❑ Drop ❑ Male ❑ Female | Last Name | First Name | Middle Initial | PCP Number for HMO:

Social Security Number ___-___-____ | Birth Date MM DD YYYY | Mailing Address, if different | City | State | ZIP

Indicate child's relationship to employee: ❑ Natural/adopted child ❑ Stepchild ❑ Foster child ❑ Legal guardianship ❑ Grandchild** ❑ Other child**

Child ❑ Add ❑ Drop ❑ Male ❑ Female | Last Name | First Name | Middle Initial | PCP Number for HMO:

Social Security Number ___-___-____ | Birth Date MM DD YYYY | Mailing Address, if different | City | State | ZIP

Indicate child's relationship to employee: ❑ Natural/adopted child ❑ Stepchild ❑ Foster child ❑ Legal guardianship ❑ Grandchild** ❑ Other child**

** Must meet eligibility criteria specified in the first bullet under Coverage Conditions in Section 10. If additional space for dependents is needed, attach another application.

SECTION 6 — PREVIOUS COVERAGE INFORMATION This does not apply to those who enroll when first eligible, new hires or HMO enrollees.

In order to receive credit for preexisting condition waiting periods, you must provide information about prior creditable coverage for you and any dependents listed. If you have a certificate of prior coverage, please attach a copy to this enrollment application. (If more than one plan was in effect, or if information is different for dependents, attach additional pages.) If Medicare, please complete the Medicare Information in Section 3 on the front of the application.

SECTION 7 — OTHER HEALTH COVERAGE INFORMATION

Are you or any of your dependents who are enrolling for any TRS-ActiveCare plan covered by any other health coverage? ❑ Yes ❑ No
If yes, please list names of every individual covered by another health plan.

SECTION 8 — DISABLED DEPENDENT CHILD Complete for disabled children and submit Dependent Child's Statement of Disability

Name of Disabled Dependent Child	Nature of Disability
Has disability been diagnosed as permanent? ❑ Yes ❑ No If temporary, how long is disabled dependent child expected to remain disabled?	Is disabled dependent child unable to work due to the disability? ❑ Yes ❑ No

A dependent Child's Statement of Disability form is also required to enroll a disabled dependent child age 26 or over.
See your Benefits Administrator.

SECTION 9 — DECLINING HEALTH COVERAGE To decline coverage, Section 2 must also be completed

This is to certify that the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage as indicated below. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage as well as a preexisting condition exclusion period (not applicable to HMO coverage). Effective September 1, 2011, a preexisting condition waiting period is not applicable for any individual under the age of 19.

Name	❑ Employee	Reason for declining: ❑ Other Group Coverage ❑ Medicare ❑ Medicaid ❑ Other, explain:
Name	❑ Spouse	Reason for declining: ❑ Other Group Coverage ❑ Medicare ❑ Medicaid ❑ Other, explain:
Name	❑ Dependent Child	Reason for declining: ❑ Other Group Coverage ❑ Medicare ❑ Medicaid ❑ Other, explain:
Name	❑ Dependent Child	Reason for declining: ❑ Other Group Coverage ❑ Medicare ❑ Medicaid ❑ Other, explain:
Name	❑ Dependent Child	Reason for declining: ❑ Other Group Coverage ❑ Medicare ❑ Medicaid ❑ Other, explain:

Signature _____ Date _____

SECTION 10 — 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) afforded by the TRS-ActiveCare program which is administered by Blue Cross and Blue Shield of Texas, A Division of Health Care Service Corporation, with HMO benefits provided by SHA, L.L.C. dba FirstCare, Scott and White Health Plan, and Valley Baptist Insurance Company dba Valley Baptist Health Plans. On behalf of myself and any dependents listed on this Enrollment Application and Change Form, I apply for those coverage(s) for which I am eligible.
  - If I am enrolling a grandchild in Section 5, 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's support, that neither of the child'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 amounts 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 of the TRS-ActiveCare program.
- I understand that the health coverage I am applying for may be subject to a preexisting condition exclusion (not applicable to HMO coverage).
- I understand that by enrolling for coverage with the Employer named in this 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 if I terminate 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 this 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's Signature _____ Date _____