Enrollment, Change and Declination Form

ELIGIBILTY:	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

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

☐ **For New Employee** (check one): ☐ Effective on Actively at Work ☐ Effective 1st day of month following

Life Event Date: __ /__ /____ ☐ Marriage ☐ Court Order ☐ Birth/Adoption ☐ Loss of Coverage ☐ Other:

Change Only:
☐ Name
☐ Address
☐ Plan/Coverage

Decline Coverage:
☐ Yes (Complete Section 6)
☐ N/A

Effective Date of Change/Cancel
____ / ____ / _____

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

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

For District Use Only

TRS District #

Actively at Work Date:

Effective/Change Date:

Employer Approval:
_____

Were you covered by another district? ☐ Yes ☐ No
If so, which: _____

SECTION 2: EMPLOYEE INFORMATION

Last Name:	First Name:	MI:	Social Security #:
Mailing Address:	City:	State:	Zip:
Alternative Address:	City:	State:	Zip:
Home Phone Number:	Work Phone Number:	Work Email:	
Date of Birth:	Sex: ☐ M ☐ F	Language: ☐ English ☐ Spanish	Tobacco user: ☐ Yes ☐ No

Do you have a disability affecting your ability to communicate or read? ☐ Yes (Please complete Section 8) ☐ No

Is the Employee Covered By Other Insurance? ☐ Yes Carrier/Plan: ☐ No

Is the Employee Covered by Medicare? ☐ Yes ☐ Part A ☐ Part B ☐ Part C ☐ Part D Effective: ☐ No

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

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

Plan Selection: ☐ ActiveCare 1-HD ☐ ActiveCare Select ☐ ActiveCare Kelsey Select

HMO Selection: ☐ FirstCare Health Plans ☐ Scott & White Health Plan ☐ Blue Essentials Access Plan (formerly Allegian Health Plans)

Coverage Type Selected: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

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

SPOUSE Last Name:	First Name:		MI:
Street Address:			☐ Same as Employee
City:	State:	Zip:	Phone Number:
Sex: ☐ M ☐ F	Date of Birth:	Social Security #:	Tobacco user: ☐ Yes ☐ No

Other Insurance: ☐ Yes. Carrier/Plan ☐ No ☐ Medicare: ☐ Part A ☐ Part B ☐ Part C ☐ Part D

CHILD Last Name:	First Name:		MI:
☐ Child ☐ Grandchild ☐ Disabled	Tobacco user: ☐ Yes ☐ No	* required for children 18 and older	
Street Address:			☐ Same as Employee
City:	State:	Zip Code:	Phone Number:
Date of Birth:	Social Security #:		Sex: ☐ M ☐ F

Other Insurance: ☐ Yes. Carrier/Plan ☐ No ☐ Medicare: ☐ Part A ☐ Part B ☐ Part C ☐ Part D

CHILD Last Name:	First Name:		MI:
☐ Child ☐ Grandchild ☐ Disabled	Tobacco user: ☐ Yes ☐ No	* required for children 18 and older	
Street Address:			☐ Same as Employee
City:	State:	Zip Code:	Phone Number:
Date of Birth:	Social Security #:		Sex: ☐ M ☐ F

Other Insurance: ☐ Yes. Carrier/Plan ☐ No ☐ Medicare: ☐ Part A ☐ Part B ☐ Part C ☐ Part D

PLEASE CONTINUE ON NEXT PAGE

CHILD Last Name:	First Name:	MI:

☐Child ☐Grandchild ☐Disabled Tobacco user: ☐ Yes ☐ No * required for children 18 and older

Street Address: ☐Same as Employee

City:	State:	Zip Code:	Phone Number:
Date of Birth:	Social Security #:		Sex: ☐M ☐F

Other Insurance: ☐Yes. Carrier/Plan ☐No ☐Medicare: ☐Part A ☐Part B ☐Part C ☐Part D

CHILD Last Name:	First Name:	MI:

☐Child ☐Grandchild ☐Disabled Tobacco user: ☐ Yes ☐ No * required for children 18 and older

Street Address: ☐Same as Employee

City:	State:	Zip Code:	Phone Number:
Date of Birth:	Social Security #:		Sex: ☐M ☐F:

Other Insurance: ☐Yes. Carrier/Plan ☐No ☐Medicare: ☐Part A ☐Part B ☐Part C ☐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: ☐Employee Reason: ☐Other Coverage ☐Other:
Gender: ☐F ☐M Date of Birth: Address: ☐same as employee

Name: SSN: ☐Spouse Reason: ☐Other Coverage ☐Other:
Gender: ☐F ☐M Date of Birth: Address: ☐same as employee

Name: SSN: ☐Child Reason: ☐Other Coverage ☐Other:
Gender: ☐F ☐M Date of Birth: Address: ☐same as employee

Name: SSN: ☐Child Reason: ☐Other Coverage ☐Other:
Gender: ☐F ☐M Date of Birth: Address: ☐same as employee

Name: SSN: ☐Child Reason: ☐Other Coverage ☐Other:
Gender: ☐F ☐M Date of Birth: Address: ☐same as employee

Name: SSN: ☐Child Reason: ☐Other Coverage ☐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)