



Please print in blue or black ink.

**Enrollment  
Application  
and  
Change Form**

Group Number 085000

www.trs.state.tx.us/trs-activecare

**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**

<input type="checkbox"/> <b>New Enrollee</b> <input type="checkbox"/> <b>Add Dependent</b> <b>Are you applying as a result of:</b> <b>Annual Enrollment?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Special Enrollment Event?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate event date: MM DD YYYY <b>Event:</b> <input type="checkbox"/> Marriage <input type="checkbox"/> Birth or Adoption <input type="checkbox"/> Court Order <input type="checkbox"/> Loss of Other Coverage <input type="checkbox"/> Other Explain:	<b>If you are a new hire, when do you want coverage to begin?</b> <input type="checkbox"/> Actively-at-work date <input type="checkbox"/> First of the month following the actively-at-work date	<input type="checkbox"/> <b>Cancel Enrollee</b> <input type="checkbox"/> <b>Cancel Dependent</b> List names of those canceling in Section 5 <b>Event:</b> <input type="checkbox"/> Divorce* <input type="checkbox"/> Death* <input type="checkbox"/> Loss of Eligibility <input type="checkbox"/> Terminated Employment or Retirement <input type="checkbox"/> Non-Payment of Premium <input type="checkbox"/> Leave of Absence Period Expired <input type="checkbox"/> Dropped Coverage (Employee Request) <input type="checkbox"/> Other Explain: Indicate event date: MM DD YYYY	<input type="checkbox"/> <b>Change</b> <input type="checkbox"/> Plan/Coverage <input type="checkbox"/> Address <input type="checkbox"/> Name  <input type="checkbox"/> <b>Declining Coverage</b> (Complete Sections 2 & 9)
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**For Employer Use Only**

TRS Reporting Number

Employee's Actively-at-Work Date

Effective Date of Coverage

Employer Verification Signature

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

<input type="checkbox"/> Male <input type="checkbox"/> Married	Last Name	First Name	Middle Initial
<input type="checkbox"/> Female <input type="checkbox"/> Single			
Birth Date	Social Security Number	Work Phone Number	Home Phone Number
MM DD YYYY	- -	( )	( )
Mailing Address	City	State	ZIP

**Complete only if you are applying for HMO Coverage**

Primary Language:	Do you have a disability affecting your ability to communicate or read: <input type="checkbox"/> Yes <input type="checkbox"/> 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)

<b>Name of person covered:</b>	<b>HIC# (from ID card):</b>
<input type="checkbox"/> Medicare Part A (hospital)	<input type="checkbox"/> Medicare Part B (medical)
Start Date: MM DD YYYY    End Date: MM DD YYYY	Start Date: MM DD YYYY    End Date: MM DD YYYY
<input type="checkbox"/> Medicare Part C <input type="checkbox"/> w/drugs OR <input type="checkbox"/> without drugs	<input type="checkbox"/> Medicare Part D (prescription drugs)
Start Date: MM DD YYYY    End Date: MM DD YYYY	Start Date: MM DD YYYY    End Date: MM DD YYYY
Check reason for Medicare eligibility: <input type="checkbox"/> Entitled age <input type="checkbox"/> Entitled disability <input type="checkbox"/> End-stage renal disease <input type="checkbox"/> Disability and current renal disease	

**SECTION 4 — SELECT YOUR PLAN AND COVERAGE CATEGORY**

<b>Health Benefits Plan</b> (Check one)	<b>Coverage Category</b> (Check one)
PPO: <input type="checkbox"/> ActiveCare 1 <input type="checkbox"/> ActiveCare 2 <input type="checkbox"/> ActiveCare 3	<input type="checkbox"/> Employee Only
HMO: <input type="checkbox"/> FirstCare <input type="checkbox"/> Legacy Health Solutions <input type="checkbox"/> Mercy Health Plans <input type="checkbox"/> Scott & White Health Plan <input type="checkbox"/> Valley Baptist Health Plans	<input type="checkbox"/> Employee and Spouse
	<input type="checkbox"/> Employee and Child(ren)
	<input type="checkbox"/> Employee and Family

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

<b>Spouse</b>	<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	Middle Initial	PCP Number for HMO:
Social Security Number	Birth Date	Mailing Address, if different	City	State	ZIP	
- -	MM DD YYYY					
<b>Child</b>	<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	Middle Initial	PCP Number for :
Social Security Number	Birth Date	Mailing Address, if different	City	State	ZIP	
- -	MM DD YYYY					
Indicate child's relationship to employee: <input type="checkbox"/> Natural/adopted child <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster child <input type="checkbox"/> Legal guardianship <input type="checkbox"/> Grandchild** <input type="checkbox"/> Other child**						
<b>Child</b>	<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	Middle Initial	PCP Number for HMO:
Social Security Number	Birth Date	Mailing Address, if different	City	State	ZIP	
- -	MM DD YYYY					
Indicate child's relationship to employee: <input type="checkbox"/> Natural/adopted child <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster child <input type="checkbox"/> Legal guardianship <input type="checkbox"/> Grandchild** <input type="checkbox"/> 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**

<b>Child</b>	<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	Middle Initial	PCP Number for HMO:
Social Security Number			Birth Date	Mailing Address, if different	City	State ZIP
Indicate child's relationship to employee:			<input type="checkbox"/> Natural/adopted child <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster child <input type="checkbox"/> Legal guardianship <input type="checkbox"/> Grandchild** <input type="checkbox"/> Other child**			

<b>Child</b>	<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	Middle Initial	PCP Number for :
Social Security Number			Birth Date	Mailing Address, if different	City	State ZIP
Indicate child's relationship to employee:			<input type="checkbox"/> Natural/adopted child <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster child <input type="checkbox"/> Legal guardianship <input type="checkbox"/> Grandchild** <input type="checkbox"/> Other child**			

<b>Child</b>	<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	Middle Initial	PCP Number for HMO:
Social Security Number			Birth Date	Mailing Address, if different	City	State ZIP
Indicate child's relationship to employee:			<input type="checkbox"/> Natural/adopted child <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster child <input type="checkbox"/> Legal guardianship <input type="checkbox"/> Grandchild** <input type="checkbox"/> 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 that 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, age 25 or over, and submit Dependent Child's Statement of Disability**

Name of Disabled Dependent Child	Nature of Disability
Has disability been diagnosed as permanent? <input type="checkbox"/> Yes <input type="checkbox"/> No If temporary, how long is disabled dependent child expected to remain disabled?	Is disabled dependent child unable to work due to the disability? <input type="checkbox"/> Yes <input type="checkbox"/> No

To enroll a disabled dependent child age 25 or over, a Dependent Child's Statement of Disability form is also required. 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).

<b>Name</b> <input type="checkbox"/> Employee	Reason for declining: <input type="checkbox"/> Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, explain:
<b>Name</b> <input type="checkbox"/> Spouse	Reason for declining: <input type="checkbox"/> Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, explain:
<b>Name</b> <input type="checkbox"/> Dependent Child	Reason for declining: <input type="checkbox"/> Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, explain:
<b>Name</b> <input type="checkbox"/> Dependent Child	Reason for declining: <input type="checkbox"/> Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, explain:
<b>Name</b> <input type="checkbox"/> Dependent Child	Reason for declining: <input type="checkbox"/> Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> 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 with HMO benefits provided by SHA, L.L.C. dba FirstCare, Legacy Health Solutions, Inc., Mercy Health Plans of Missouri, Inc., 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.
- 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 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 \_\_\_\_\_



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Group Number 085000    www.trs.state.tx.us/trs-activecare    Toll-Free Customer Service 1.866.355.9999

This form is to be completed by both husband and wife who wish to split the cost of employee and spouse or employee and family coverage while being employed by different districts/entities participating in TRS-ActiveCare.

The employee identified in Section 1 is required to select a plan under TRS-ActiveCare. The employee's spouse, identified in Section 3, is required to decline (waive) TRS-ActiveCare coverage. The employing district/entity for EACH person must also complete Sections 2 or 4, as appropriate.

The cost for TRS-ActiveCare coverage will be split between the two employers. Each employer will be billed 50% of the total cost of the TRS-ActiveCare plan selected by the employee in Section 1.

The entity employing the spouse who declined coverage will consider the employee as covered under a group health plan for funding purposes.

**SECTION 1 — TO BE COMPLETED BY EMPLOYEE** that has elected employee and spouse or employee and family coverage

Employee Last Name	First Name	Middle Initial	Social Security Number

I have elected employee and spouse or employee and family coverage, and I elect to split the cost of coverage 50/50 with my spouse.

Employee Signature

Date

**SECTION 2 — TO BE COMPLETED BY EMPLOYER** of the employee in Section 1

District/Entity Name	TRS Reporting Number

I confirm this employee is an active employee enrolled for TRS-ActiveCare coverage. I understand that the cost of this employee's coverage will be split 50/50 between our district/entity and the participating district/entity of the employee's spouse.

Employer Verification Signature

Date

**SECTION 3 — TO BE COMPLETED BY EMPLOYEE** that will be declining coverage

Employee Last Name	First Name	Middle Initial	Social Security Number

I elect to split the cost of coverage 50/50 with my spouse. I have declined TRS-ActiveCare coverage under my participating district/entity and will be covered as a dependent of my spouse as listed in Section 1.

Employee Signature

Date

**SECTION 4 — TO BE COMPLETED BY EMPLOYER** of the employee in Section 3

District/Entity Name	TRS Reporting Number

I confirm this employee is an active employee who has declined TRS-ActiveCare coverage. I understand that 50% of the cost of coverage elected by this employee's spouse will be billed to our district/entity.

Employer Verification Signature

Date

**SECTION 5 — TO BE COMPLETED BY EMPLOYER** of the employee in Section 3 to TERMINATE SPLIT PREMIUM

District/Entity Name	TRS Reporting Number

Please terminate the split premium funding arrangement for this employee.

Employer Verification Signature

Date