

## 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.												
<b>Option 1: Enrollments</b>												
<input type="checkbox"/> Annual Enrollment <input type="checkbox"/> Add Dependent <input type="checkbox"/> New Employee* <input type="checkbox"/> Special Enrollment**	*Choose effective date if selecting <b>New Employee:</b> <input type="checkbox"/> Effective on actively at work <input type="checkbox"/> Effective 1 <sup>st</sup> day of the following month	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #cccccc;"> <th colspan="2" style="text-align: center; padding: 2px;">For District Use Only</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;">TRS District #:</td> <td style="padding: 2px;"></td> </tr> <tr> <td style="padding: 2px;">Actively at Work Date:</td> <td style="padding: 2px;"> / /</td> </tr> <tr> <td style="padding: 2px;">Effective/Change Date:</td> <td style="padding: 2px;"> / /</td> </tr> <tr> <td style="padding: 2px;">Employer Approval:</td> <td style="padding: 2px;"></td> </tr> </tbody> </table>	For District Use Only		TRS District #:		Actively at Work Date:	/ /	Effective/Change Date:	/ /	Employer Approval:	
For District Use Only												
TRS District #:												
Actively at Work Date:	/ /											
Effective/Change Date:	/ /											
Employer Approval:												
**Choose a Life Event type if selecting <b>Special Enrollment:</b>												
<input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Loss of Coverage*** <input type="checkbox"/> Court Order <input type="checkbox"/> Other: _____	***If you selected <b>Loss of Coverage</b> please specify: <b>Cancel Employee:</b> <input type="checkbox"/> Death <input type="checkbox"/> Loss of Eligibility <input type="checkbox"/> Retirement/Terminated <input type="checkbox"/> Non-Payment <input type="checkbox"/> Other: _____	<b>Cancel Dependent:</b> <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Loss of Eligibility <input type="checkbox"/> Dropped Coverage <input type="checkbox"/> Other: _____										
Date of Life Event: ____ / ____ / ____												
Were you previously covered by a different district? <input type="checkbox"/> Yes <input type="checkbox"/> No												
If yes, District Name: _____												
<b>Option 2: Changes</b>	<b>Option 3: Decline Coverage</b>											
<input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Plan/Coverage	<input type="checkbox"/> Yes <input type="checkbox"/> N/A											
Effective Date of Change: ____ / ____ / ____												
<b>Section 2: Employee Information</b>												
Last Name: _____ First Name: _____ MI: ____ SSN: ____ - ____ - ____												
Address: _____ City: _____ State: _____ Zip: _____												
Alternate Address: _____ City: _____ State: _____ Zip: _____												
Date of Birth: ____ / ____ / ____ Work Phone: ____ - ____ - ____ Work Email: _____												
Sex: <input type="checkbox"/> M <input type="checkbox"/> F Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish Tobacco User: <input type="checkbox"/> Yes <input type="checkbox"/> No Race/Ethnicity: _____												
Are you covered by other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No												
Reason for Medicare Coverage: <input type="checkbox"/> Entitlement Age <input type="checkbox"/> Disability <input type="checkbox"/> End State Renal Disease (ESRD)	Medicare Coverage Type: <input type="checkbox"/> Medicare A and D Primary <input type="checkbox"/> Medicare A, B, and D Primary <input type="checkbox"/> Medicare B and D Primary <input type="checkbox"/> Medicare D Primary <input type="checkbox"/> Medicare A Primary											
<input type="checkbox"/> Medicare A and B Primary <input type="checkbox"/> Medicare B Primary <input type="checkbox"/> Medicare Unknown <input type="checkbox"/> Other Coverage												
<b>Section 3: Coverage Selection</b>												
<b>Plan Selection:</b> <input type="checkbox"/> ActiveCare 1-HD <input type="checkbox"/> ActiveCare Select <input type="checkbox"/> ActiveCare 2 <input type="checkbox"/> ActiveCare Baptist Select* <input type="checkbox"/> ActiveCare Baylor Select* <input type="checkbox"/> ActiveCare Kelsey Select* <input type="checkbox"/> ActiveCare Memorial Hermann Select* <input type="checkbox"/> ActiveCare Seton Select*	<b>HMO Selection:</b> <input type="checkbox"/> First Care Health Plans OR <input type="checkbox"/> Scott & White Plan <input type="checkbox"/> Blue Essential Access Plan	<b>Coverage Tier:</b> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family										
*plan eligibility is determined by home address zip code												

**Section 4: Primary Care Provider (PCP)**

To elect coverage in the ActiveCare 1-HD if you or your dependents live in Harris, Fort Bend, Brazoria, Galveston, or Montgomery counties 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. You can find your PCP number by contacting your provider or by going to [www.TRSAActiveCareAetna.com](http://www.TRSAActiveCareAetna.com) and clicking on *Find a Doctor or Facility*. If you do not have a PCP you can look up a provider in your area at the website address above. You must list a PCP for all dependents listed below.

If you enroll in ActiveCare 1-HD 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, please call the TRS-ActiveCare Service Center at (833) 682-8972.

Primary Physician name: \_\_\_\_\_

Provider 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 Physician Name: \_\_\_\_\_

Provider ID #: \_\_\_\_\_

Are you covered by other insurance?  Yes  No If yes, Carrier/Plan: \_\_\_\_\_

Tobacco User:  Yes  No

If Medicare, select a coverage type:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Medicare A and D Primary     | <input type="checkbox"/> Medicare D Primary       | <input type="checkbox"/> Medicare B Primary |
| <input type="checkbox"/> Medicare A, B, and D Primary | <input type="checkbox"/> Medicare A Primary       | <input type="checkbox"/> Medicare Unknown   |
| <input type="checkbox"/> Medicare B and D Primary     | <input type="checkbox"/> Medicare A and B Primary | <input type="checkbox"/> 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 Physician Name: \_\_\_\_\_

Provider ID #: \_\_\_\_\_

Are you covered by other insurance?  Yes  No If yes, Carrier/Plan: \_\_\_\_\_

If Medicare, select a coverage type:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Medicare A and D Primary     | <input type="checkbox"/> Medicare D Primary       | <input type="checkbox"/> Medicare B Primary |
| <input type="checkbox"/> Medicare A, B, and D Primary | <input type="checkbox"/> Medicare A Primary       | <input type="checkbox"/> Medicare Unknown   |
| <input type="checkbox"/> Medicare B and D Primary     | <input type="checkbox"/> Medicare A and B Primary | <input type="checkbox"/> 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 Physician Name: \_\_\_\_\_

Provider ID #: \_\_\_\_\_

Are you covered by other insurance?  Yes  No If yes, Carrier/Plan: \_\_\_\_\_

If Medicare, select a coverage type:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Medicare A and D Primary     | <input type="checkbox"/> Medicare D Primary       | <input type="checkbox"/> Medicare B Primary |
| <input type="checkbox"/> Medicare A, B, and D Primary | <input type="checkbox"/> Medicare A Primary       | <input type="checkbox"/> Medicare Unknown   |
| <input type="checkbox"/> Medicare B and D Primary     | <input type="checkbox"/> Medicare A and B Primary | <input type="checkbox"/> 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: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 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: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 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 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 and must be **submitted within 31 days** of the child's 26<sup>th</sup> birthday. See your Benefits Administrator for the forms, 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: _____ - _____ - _____ <input type="checkbox"/> Employee Gender: <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth: ____/____/____ <input type="checkbox"/> Other Coverage: _____ Address: _____
Name: _____ SSN: _____ - _____ - _____ <input type="checkbox"/> Spouse Gender: <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth: ____/____/____ <input type="checkbox"/> Other Coverage: _____ Address: _____ <input type="checkbox"/> Same as Employee
Name: _____ SSN: _____ - _____ - _____ <input type="checkbox"/> Child Gender: <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth: ____/____/____ <input type="checkbox"/> Other Coverage: _____ Address: _____ <input type="checkbox"/> Same as Employee
Name: _____ SSN: _____ - _____ - _____ <input type="checkbox"/> Child Gender: <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth: ____/____/____ <input type="checkbox"/> Other Coverage: _____ Address: _____ <input type="checkbox"/> Same as Employee
Name: _____ SSN: _____ - _____ - _____ <input type="checkbox"/> Child Gender: <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth: ____/____/____ <input type="checkbox"/> Other Coverage: _____ Address: _____ <input type="checkbox"/> Same as Employee
Name: _____ SSN: _____ - _____ - _____ <input type="checkbox"/> Child Gender: <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth: ____/____/____ <input type="checkbox"/> Other Coverage: _____ Address: _____ <input type="checkbox"/> 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 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, 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 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 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 of 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: \_\_\_\_/\_\_\_\_/\_\_\_\_