Application to Terminate Split Premium

Please Print in blue or black ink.

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 percent 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 THE EMPLOYEE TERMINATING SPLIT PREMIUM COVERAGE

Employee Last Name	First Name	MI

Employee Social Security Number

			-			-				

I have elected to terminate split premium coverage.

Employee Signature ________________________ **Date** ____________

SECTION 2 TO BE COMPLETED BY EMPLOYEE WHO PREVIOUSLY DECLINED COVERAGE

Employee Last Name	First Name	MI

Employee Social Security Number

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I elect to decline spilt coverage, and now be responsible for 100 percent of coverage for my own insurance or my spouse and/or family's insurance coverage (mentioned in section 1).

Employee Signature ________________________ **Date** ____________

SECTION 3 TO BE COMPLETED BY EMPLOYER of the employee in Section 1

District/Entity Name	TRS Reporting Number

I confirm that this employee is an active employee who will be now be electing TRS-ActiveCare coverage for themselves, and may or may not be the primary insurer for their spouse or family.

Employer Verification Signature ________________________ **Date** ____________

SECTION 4 TO BE COMPLETED BY EMPLOYER of the employee in Section 2 to TERMINATE SPLIT PREMIUM

District/Entity Name	TRS Reporting Number

Please terminate the split premium funding arrangement for this employee. | Effective Date

Employer Verification Signature ________________________ **Date** ____________

Submit to: WellSystems Via Your Enrollment Coordinator's Dedicated Fax or E-Mail