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.**

Option 1: Enrollments

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

*Choose effective date if selecting **New Employee**:
☐ Effective on actively at work
☐ Effective 1st day of the following month

For District Use Only
TRS District #:
Actively at Work Date: / /
Effective/Change Date: / /
Employer Approval:

Choose a Life Event type if selecting **Special Enrollment:

☐ Marriage
☐ Birth/Adoption
☐ Loss of Coverage***
☐ Court Order
☐ Other: _____

***If you selected **Loss of Coverage** please specify:

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

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

Date of Life Event:____/____/_____

Were you previously covered by a different district? ☐ Yes ☐ No

If yes, District Name: _____

Option 2: Changes

☐ Name
☐ Address
☐ Plan/Coverage

Effective Date of Change:____/____/_____

Option 3: Decline Coverage

☐ Yes
☐ N/A

*If selecting yes, must complete Section 6

Section 2: Employee Information

Last Name:_____ First Name:_____ MI: ____ SSN:____-____-____

Address: _____ City: _____ State: _____ Zip:_____

Alternate Address: _____ City: _____ State: _____ Zip:_____

Date of Birth:____/____/_____ Work Phone:____-____-_____ Work Email:_____

Sex: ☐ M ☐ F Language: ☐ English ☐ Spanish Tobacco User: ☐ Yes ☐ No Race/Ethnicity: _____

Are you covered by other insurance? ☐ Yes ☐ No

Are you covered by Medicare? ☐ Yes ☐ No

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

Medicare Coverage Type:
☐ Medicare A and D Primary
☐ Medicare A, B, and D Primary
☐ Medicare B and D Primary
☐ Medicare D Primary
☐ Medicare A Primary
☐ Medicare A and B Primary
☐ Medicare B Primary
☐ Medicare Unknown
☐ Other Coverage

Section 3: Coverage Selection

Plan Selection:
☐ ActiveCare 1-HD
☐ ActiveCare Select
☐ ActiveCare 2
☐ ActiveCare Baptist Select*
☐ ActiveCare Baylor Select*
☐ ActiveCare Kelsey Select*
☐ ActiveCare Memorial Hermann Select*
☐ ActiveCare Seton Select*

OR

HMO Selection:
☐ First Care Health Plans
☐ Scott & White Plan
☐ Blue Essential Access Plan

Coverage Tier:
☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ 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.TRSActiveCareAetna.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:

☐ 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: ___ - ___ - ____

Primary Physician Name: _____

Provider ID #: _____

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: ___ - ___ - ____

Primary Physician Name: _____

Provider ID #: _____

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

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 26th 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: ____-____-____ ☐Employee
Gender: ☐ M ☐F Date of Birth:____/____/____ ☐Other Coverage:________________
Address: ________________

Name: ________________ SSN: ____-____-____ ☐Spouse
Gender: ☐ M ☐F Date of Birth: ____/____/____ ☐Other Coverage:________________
Address: ________________ ☐ Same as Employee

Name: ________________ SSN: ____-____-____ ☐Child
Gender: ☐ M ☐F Date of Birth: ____/____/____ ☐Other Coverage:________________
Address: ________________ ☐ Same as Employee

Name: ________________ SSN: ____-____-____ ☐Child
Gender: ☐ M ☐F Date of Birth:____/____/____ ☐Other Coverage:________________
Address: ________________ ☐ Same as Employee

Name: ________________ SSN: ____-____-____ ☐Child
Gender: ☐ M ☐F Date of Birth:____/____/____ ☐Other Coverage:________________
Address: ________________ ☐ Same as Employee

Name: ________________ SSN: ____-____-____ ☐Child
Gender: ☐ M ☐F Date of Birth:____/____/____ ☐Other Coverage: ________________
Address: ________________ ☐ 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 or 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: ____/____/____