

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**

**New Enrollee**     **Add Dependent**  
**Are you applying as a result of:**  
**Annual Enrollment?**     Yes     No  
**Special Enrollment Event?**     Yes     No  
 If yes, indicate event date: MM DD YYYY  
**Event:**     Marriage     Birth or Adoption  
            Court Order     Loss of Other Coverage  
            Other Explain:

**If you are a new hire, when do you want coverage to begin?**  
 Actively-at-work date  
 First of the month following the actively-at-work date  
 First of the month in which TRS membership begins (only if subject to a 90-day waiting period)

**Cancel Enrollee**     **Cancel Dependent**  
 List names of those canceling in Section 5  
**Event:**     Divorce\*     Death\*     Loss of Eligibility  
 Terminated Employment or Retirement  
 Non-Payment of Premium  
 Leave of Absence Period Expired  
 Dropped Coverage (Employee Request)  
 Other Explain:  
 Indicate event date: MM DD YYYY

**Change**  
 Plan/Coverage  
 Address  
 Name

**Declining Coverage**  
 (Complete Sections 2 & 9)

**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

Male     Married    Last Name    First Name    Middle Initial  
 Female     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:  Yes     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

Name of Person on Medicare     Medicare Part A    Effective Date    Medicare Number  
 MM DD YYYY

If additional space is needed, please attach another application.     Medicare Part B    Effective Date    End Stage Renal Disease     Yes     No  
 MM DD YYYY

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

**Health Benefits Plan** (Check one)  
**PPO:**     ActiveCare 1     ActiveCare 2     ActiveCare 3  
**HMO:**     FIRSTCARE     Mercy Health Plans     Scott & White Health Plan     Valley Baptist Health Plan

**Coverage Category** (Check one)  
 Employee Only     Employee and Spouse  
 Employee and Child(ren)     Employee and Family

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

**Spouse**     Add     Male    Last Name    First Name    Middle Initial    PCP Number for HMO:  
 Drop     Female

Social Security Number    Birth Date    Mailing Address, if different    City    State    ZIP  
 MM DD YYYY

**Child**     Add     Male    Last Name    First Name    Middle Initial    PCP Number for HMO:  
 Drop     Female

Social Security Number    Birth Date    Mailing Address, if different    City    State    ZIP  
 MM DD YYYY

Indicate child's relationship to employee:     Natural/adopted child     Stepchild     Foster child     Legal guardianship     Grandchild\*\*     Other child\*\*

**Child**     Add     Male    Last Name    First Name    Middle Initial    PCP Number for HMO:  
 Drop     Female

Social Security Number    Birth Date    Mailing Address, if different    City    State    ZIP  
 MM DD YYYY

Indicate child's relationship to employee:     Natural/adopted child     Stepchild     Foster child     Legal guardianship     Grandchild\*\*     Other child\*\*

**Child**     Add     Male    Last Name    First Name    Middle Initial    PCP Number for HMO:  
 Drop     Female

Social Security Number    Birth Date    Mailing Address, if different    City    State    ZIP  
 MM DD YYYY

Indicate child's relationship to employee:     Natural/adopted child     Stepchild     Foster child     Legal guardianship     Grandchild\*\*     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"/> Male	Last Name	First Name	Middle Initial	PCP Number for HMO:		
	<input type="checkbox"/> Drop	<input type="checkbox"/> Female						
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"/> Male	Last Name	First Name	Middle Initial	PCP Number for HMO:		
	<input type="checkbox"/> Drop	<input type="checkbox"/> Female						
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 Complete for disabled children, age 25 or over, and submit Dependent Child's Statement of Disability**

Name of Disabled Dependent	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 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, Mercy Health Plans of Missouri, Inc., Scott and White Health Plan, and Valley Baptist Health Plan, Inc. 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 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 \_\_\_\_\_