

**TRS-ActiveCare**  
**DECLINATION CERTIFICATION**  
**Group #085000**  
**Mansfield ISD**  
**TRS #0859**

This is to certify that the available health 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).

Employee Name: \_\_\_\_\_ SSN: \_\_\_\_\_

**New Hire** Actively-at-work Date: \_\_\_\_\_ (to be completed if a New Hire)

**Open Enrollment for Plan Year:** \_\_\_\_\_

<input type="checkbox"/> I am <b>enrolling</b> myself and <b>declining</b> coverage for those listed below.	<input type="checkbox"/> I am <b>declining</b> coverage for myself and my spouse/dependents.
	Employee name: _____ Reason for declining: ___ Other Group Coverage ___ Medicare ___ Medicaid ___ Other, explain: _____
Spouse name: _____ Reason for declining: ___ Other Group Coverage ___ Medicare ___ Medicaid ___ Other, explain: _____	Spouse name: _____ Reason for declining: ___ Other Group Coverage ___ Medicare ___ Medicaid ___ Other, explain: _____
Dependent Child name: _____ Reason for declining: ___ Other Group Coverage ___ Medicare ___ Medicaid ___ Other, explain: _____	Dependent Child name: _____ Reason for declining: ___ Other Group Coverage ___ Medicare ___ Medicaid ___ Other, explain: _____
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Dependent Child name: _____ Reason for declining: ___ Other Group Coverage ___ Medicare ___ Medicaid ___ Other, explain: _____	Dependent Child name: _____ Reason for declining: ___ Other Group Coverage ___ Medicare ___ Medicaid ___ Other, explain: _____

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please mail completed form to:**  
**Blue Cross & Blue Shield of Texas**  
**TRS-ActiveCare**  
**P.O. Box 660400**  
**Dallas, Texas 75266-0400**