

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

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

SECTION 4 — SELECT YOUR PLAN AND COVERAGE CATEGORY

Health Benefits Plan (Check one)
PPO: ActiveCare 1 ActiveCare 2 ActiveCare 3
HMO: FirstCare Legacy Health Solutions Mercy Health Plans Scott & White Health Plan Valley Baptist Health Plans
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 Drop Male Female Last Name First Name Middle Initial PCP Number for HMO:
Social Security Number Birth Date MM DD YYYY Mailing Address, if different City State ZIP

Child Add Drop Male Female Last Name First Name Middle Initial PCP Number for :
Social Security Number Birth Date MM DD YYYY Mailing Address, if different City State ZIP

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

Child Add Drop Male Female Last Name First Name Middle Initial PCP Number for HMO:
Social Security Number Birth Date MM DD YYYY Mailing Address, if different City State ZIP

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

Child Add Drop Male Female Last Name First Name Middle Initial PCP Number for HMO:
Social Security Number Birth Date MM DD YYYY Mailing Address, if different City State ZIP

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

Child	<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name _____	First Name _____	Middle Initial _____	PCP Number for :
Social Security Number _____			Birth Date _____ <small>MM DD YYYY</small>	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**						

Child	<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name _____	First Name _____	Middle Initial _____	PCP Number for HMO:
Social Security Number _____			Birth Date _____ <small>MM DD YYYY</small>	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 CHILD Complete for disabled children, age 25 or over, and submit Dependent Child's Statement of Disability

Name of Disabled Dependent Child _____	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 child 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).

Name <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: _____
Name <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: _____
Name <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: _____
Name <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: _____
Name <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, Legacy Health Solutions, Inc., Mercy Health Plans of Missouri, Inc., Scott and White Health Plan, and Valley Baptist Insurance Company dba Valley Baptist Health Plans. 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 understand that by enrolling for coverage with the Employer named in this Enrollment Application and Change Form 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 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 _____