

Please print in blue or black ink.

Group Number 085000

[www.trs.state.tx.us/trs-activecare](http://www.trs.state.tx.us/trs-activecare)

1. District/Entity Name \_\_\_\_\_
2. TRS Reporting Number
3. Effective Date with TRS-ActiveCare \_\_\_\_\_
4. Address \_\_\_\_\_  
\_\_\_\_\_
5. Contact Name \_\_\_\_\_
6. Contact Person Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_
7. Internet/E-mail Address (if available) \_\_\_\_\_
8. **Attach** a complete list of COBRA participants or dependents, including all information listed below. (Normally all this information is found on reports that can be obtained from your existing COBRA vendor.)

PARTICIPANT EMPLOYEE (S)	PARTICIPANT DEPENDENT (S)
Name	Name
Address	Social Security number
Phone number (if available)	Date of birth
Social Security number	Type of coverage elected
Date of birth	
Qualified event date	
Qualified event reason	
Current paid-to date of COBRA premiums	
Type of coverage elected	

9. Name/Contact of prior COBRA administrator vendor (if applicable)

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Form completed by)

If you have any questions about how to complete this form, please contact Health Care Service Corporation at 1-888-541-7107. Hours of operation are Monday through Friday, 7:30 a.m. till 5:00 p.m. (Central Time).

**Please return completed form and any additional documentation to:**

Health Care Service Corporation  
COBRA Administration  
P.O. Box 1180  
Marion, IL 62959-7680

E-mail: [COBRA@bcbsil.com](mailto:COBRA@bcbsil.com)  
FAX: (618) 998-2747