



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

Home E-Mail Address

**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 (Attach another application if more space is needed)

**Name of person covered:**   **HIC# (from ID card):**

Medicare Part A (hospital)   Start Date: MM DD YYYY   End Date: MM DD YYYY  
 Medicare Part B (medical)   Start Date: MM DD YYYY   End Date: MM DD YYYY

Medicare Part C    w/drugs OR    without drugs   Start Date: MM DD YYYY   End Date: MM DD YYYY  
 Medicare Part D (prescription drugs)   Start Date: MM DD YYYY   End Date: MM DD YYYY

Check reason for Medicare eligibility:    Entitled age    Entitled disability    End-stage renal disease    Disability and current renal disease

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

**Health Benefits Plan** (Check one)  
PPO:    ActiveCare 1-HD    ActiveCare 1    ActiveCare 2    ActiveCare 3  
HMO:    FirstCare    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\*\*

\* 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"/> Drop	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	Middle Initial	PCP Number for HMO:
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"/> Drop	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	Middle Initial	PCP Number for :
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"/> Drop	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	Middle Initial	PCP Number for HMO:
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 who 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, A Division of Health Care Service Corporation, with HMO benefits provided by SHA, L.L.C. dba FirstCare, 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 understand that if I terminate TRS-ActiveCare coverage during the plan year, I am not eligible to re-enroll in TRS-ActiveCare until the next plan year, even if I experience a special enrollment event.
- 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 \_\_\_\_\_