

Exception Request Form

Complete all highlighted fields, then use "Save and Submit" button at the bottom of the form to e-mail the request to TRS (HIBExceptions@trs.state.tx.us).

Request date:
MM/DD/YYYY

Is the request for exception subject to Section 125 Cafeteria Plan rules? Yes No
If "yes," do not submit an exception request unless it can be processed by the district or entity.

Does the request for exception meet the definition of "good cause" as described on page 31 of the TRS-ActiveCare Administrative Guide? Yes No
If "no," do not submit an exception request. It will be denied.

Requestor Information

Requestor/Benefits Administrator's name:
Title:
District or entity name:
TRS reporting number:
Phone number: Extension:
xxx-xxx-xxxx
Email address:

Employee and Current Coverage Information

Employee's name:
UID number: Date of Birth:
Social Security number: MM/DD/YYYY
Phone number: Extension:
xxx-xxx-xxxx
Email address:

Health benefit plan: ActiveCare 1 - HD FirstCare Not currently enrolled
 ActiveCare 1 Scott & White
 ActiveCare 2 Valley Baptist
 ActiveCare 3

Coverage category: Employee only Employee and children
 Employee and spouse Employee and family

Coverage effective date, if applicable: Current cancellation effective date, if applicable:
MM/DD/YYYY MM/DD/YYYY

Type of request: Add dependent Drop dependent Credits – billing adjustment (retroactively cancel/retroactively drop member)
(If dual request, please check all that apply, i.e., Plan change and Add dependent) Annual enrollment Initial enrollment Special enrollment
 Change effective date Plan change Other, specify:
 COBRA Reinstatement
 Split Premium

Note: If Split Premium, add spouse's information below (Name, SSN, District, BA email, BA info)

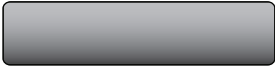
Complete all highlighted fields, then use "Save and Submit" button at the bottom of the form to e-mail the request to TRS (HIBExceptions@trs.state.tx.us).

Justification for Exception Request

Description of the exception request:

Note the coverage you want changed, added or cancelled. Please be specific; for example, include the plan and coverage category, effective dates of coverage, and dependent name(s) if applicable.

Attach any relevant supporting documentation such as COCC, enrollment application and change form, divorce decree, copy of death certificate, adoption papers, court order, online enrollment documents, or proof of payroll deductions. **If this request was not caused by an administrative error made by the district or entity, attach a written statement from the employee.**



TRS Determination

Date: _____

Approved
 Denied
 Withdrawn
 Resolved

Request/change:

Effective date: _____

Determination details:

BCBSTX processed

Date: _____

BCBSTX Rep: _____

Notes:

TRS USE ONLY