



Group Number 085000

www.trc.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:
OB/GYN 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.

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 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 HMO:
Social Security Number			Birth Date	Mailing Address, if different	City	State ZIP
			MM DD YYYY			

Indicate child's relationship to employee: Natural/adopted child Stepchild Foster child Legal guardianship Grandchild** 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	Mailing Address, if different	City	State ZIP
			MM DD YYYY			

Indicate child's relationship to employee: Natural/adopted child Stepchild Foster child Legal guardianship Grandchild** 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	Mailing Address, if different	City	State ZIP
			MM DD YYYY			

Indicate child's relationship to employee: Natural/adopted child Stepchild Foster child Legal guardianship Grandchild** 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.) Effective September 1, 2011, a preexisting condition waiting period is not applicable for any individual under the age of 19. 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 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

A dependent Child's Statement of Disability form is also required to enroll a disabled dependent child age 25 or over (age 26 or over, effective September 1, 2011). 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). Effective September 1, 2011, a preexisting condition waiting period is not applicable for any individual under the age of 19.

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 for the reporting year in which coverage of the grandchild is in effect.
- 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). Effective September 1, 2011, a preexisting condition waiting period is not applicable for any individual under the age of 19.
- 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, unless 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 _____