



Please print in blue or black ink.

Group Number 085000

www.trrs.state.tx.us/trrs-activecare

Toll-Free Customer Service 1.866.355.5999

This form is to be completed by both husband and wife who wish to split the cost of employee and spouse or employee and family coverage while being employed by different districts/entities participating in TRS-ActiveCare.

The employee identified in Section 1 is required to select a plan under TRS-ActiveCare. The employee's spouse, identified in Section 3, is required to decline (waive) TRS-ActiveCare coverage. The employing district/entity for EACH person must also complete Sections 2 or 4, as appropriate.

The cost for TRS-ActiveCare coverage will be split between the two employers. Each employer will be billed 50 percent of the total cost of the TRS-ActiveCare plan selected by the employee in Section 1.

The entity employing the spouse who declined coverage will consider the employee as covered under a group health plan for funding purposes.

**SECTION 1 — TO BE COMPLETED BY EMPLOYEE** that has elected employee and spouse or employee and family coverage

Employee Last Name	First Name	Middle Initial	Social Security Number
			-    -
I have elected employee and spouse or employee and family coverage, and I elect to split the cost of coverage 50/50 with my spouse.			
Employee Signature			Date

**SECTION 2 — TO BE COMPLETED BY EMPLOYER** of the employee in Section 1

District/Entity Name	TRS Reporting Number
I confirm this employee is an active employee enrolled for TRS-ActiveCare coverage. I understand that the cost of this employee's coverage will be split 50/50 between our district/entity and the participating district/entity of the employee's spouse.	Effective Date
Employer Verification Signature	Date

**SECTION 3 — TO BE COMPLETED BY EMPLOYEE** that will be declining coverage

Employee Last Name	First Name	Middle Initial	Social Security Number
			-    -
I elect to split the cost of coverage 50/50 with my spouse. I have declined TRS-ActiveCare coverage under my participating district/entity and will be covered as a dependent of my spouse as listed in Section 1.			
Employee Signature			Date

**SECTION 4 — TO BE COMPLETED BY EMPLOYER** of the employee in Section 3

District/Entity Name	TRS Reporting Number
I confirm this employee is an active employee who has declined TRS-ActiveCare coverage. I understand that 50 percent of the cost of coverage elected by this employee's spouse will be billed to our district/entity.	
Employer Verification Signature	Date

**SECTION 5 — TO BE COMPLETED BY EMPLOYER** of the employee in Section 3 to TERMINATE SPLIT PREMIUM

District/Entity Name	TRS Reporting Number
Please terminate the split premium funding arrangement for this employee.	
	Effective Date
Employer Verification Signature	Date



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ELIGIBILITY

Are you actively employed and making monthly contributions to TRS? ... If no, are you regularly scheduled to work 10 or more hours per week?

SECTION 1 — ENROLLMENT EVENTS Check all that apply

District/Employer Name, New Enrollee, Add Dependent, Annual Enrollment?, Special Enrollment Event?, If you are a new hire, when do you want coverage to begin?, Cancel Enrollee, Cancel Dependent, Change, Declining Coverage

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, Birth Date, 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?, Describe special communication materials needed, PCP Number for HMO, 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, Medicare Part B, Medicare Part C, Medicare Part D, Check reason for Medicare eligibility

SECTION 4 — SELECT YOUR PLAN AND COVERAGE CATEGORY

Health Benefits Plan (Check one), Coverage Category (Check one), PPO, HMO

SECTION 5 — DEPENDENT COVERAGE Complete to apply for or make changes to dependent coverage

Spouse, Child, Add, Drop, Male, 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

\* 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  Add  Drop  Male  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:  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 :
Social Security Number Birth Date 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 Mailing Address, if different City State ZIP
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.) 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?  Yes  No
If temporary, how long is disabled dependent child expected to remain disabled? Is disabled dependent child unable to work due to the disability?  Yes  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).

Table with 2 columns: Name (Employee, Spouse, Dependent Child) and Reason for declining (Other Group Coverage, Medicare, Medicaid, 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 \_\_\_\_\_