

## Enrollment, Change and Declination Form

**Eligibility:**

- Are you an active employee 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/Change Transaction Type**

\*Carefully review Options 1-3 before making any selections.

**Option 1: Enrollments**

- Annual Enrollment  
 Add Dependent  
 New Employee\*  
 Special Enrollment\*\*
- \*Choose effective date if selecting New Employee:**  
 Effective on actively at work  
 Effective 1<sup>st</sup> day of the following month

For District Use Only	
TRS District #:	
Actively at Work Date:	/ /
Effective/Change Date:	/ /
Employer Approval:	

\*\*Choose a Life Event type if selecting

\*\*\*If you selected Loss of Coverage please specify:

**Special Enrollment:**

- Marriage  
 Birth/Adoption  
 Loss of Coverage\*\*\*  
 Court Order  
 Other: \_\_\_\_\_

**Cancel Employee:**

- Death  
 Loss of Eligibility  
 Retirement/Terminated  
 Non-Payment  
 Other: \_\_\_\_\_

**Cancel Dependent:**

- Divorce  
 Death  
 Loss of Eligibility  
 Dropped Coverage  
 Other: \_\_\_\_\_

Date of Life Event: \_\_\_\_/\_\_\_\_/\_\_\_\_

Were you previously covered by a different district?  Yes  No

If yes, District Name: \_\_\_\_\_

**Option 2: Changes**

- Name  
 Address  
 Plan/Coverage

Effective Date of Change: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Option 3: Decline Coverage**

- Yes  
 N/A

\*If selecting yes, must complete Section 7

**Section 2: Employee Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ SSN: \_\_\_\_\_ - -

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Alternate Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Work Phone: - - Work Email: \_\_\_\_\_

Sex:  M  F Language:  English  Spanish Tobacco User:  Yes  No Race/Ethnicity: \_\_\_\_\_

Are you covered by other insurance?  Yes  No Are you covered by Medicare?  Yes  No

**Reason for Medicare**

- Coverage:**  
 Entitlement Age  
 Disability  
 End State Renal Disease (ESRD)

**Medicare Coverage Type:**

- Medicare A and D Primary  
 Medicare A, B and D Primary  
 Medicare B and D Primary  
 Medicare D Primary  
 Medicare A Primary
- Medicare A and B Primary  
 Medicare B Primary  
 Medicare Unknown  
 Other Coverage

**Section 3: Coverage Selection**

**Plan Selection:**

- TRS-ActiveCare Primary  
 TRS-ActiveCare HD  
 TRS-ActiveCare Primary+  
 TRS-ActiveCare 2

**Coverage Tier:**

- Employee Only  
 Employee + Spouse  
 Employee + Child(ren)  
 Employee + Family

\*plan eligibility is based on home or work location

#### Section 4: Primary Care Provider (PCP)

To elect coverage in the TRS-ActiveCare Primary, TRS-ActiveCare Primary+ or Blue Essentials HMO plans you must choose a Primary Care Provider (PCP) for yourself and your dependents. If you already have a PCP, you can enter the information in the box below.

If you are enrolling in TRS-ActiveCare Primary or TRS-ActiveCare Primary+, you can find your PCP ID number by going to [www.bcbstx.com/trsactivecare/doctors-and-hospitals](http://www.bcbstx.com/trsactivecare/doctors-and-hospitals) and clicking on the plan you're enrolling in. You will be taken to the Provider Finder search tool for that plan. Simply type in your desired PCP and input the PCP ID number found under Provider Highlights.

If you do not have a PCP, you can select one by following the link above to the Provider Finder search tool, clicking on the Browse by Category drop down, choose Medical Care and then Primary Care. You'll be able to select a PCP based off specialty and location.

If you are enrolling in Blue Essentials HMO, you can find a new PCP or your current PCP's ID number by going to [www.bcbstx.com/trshmo/doctors-and-hospitals](http://www.bcbstx.com/trshmo/doctors-and-hospitals) and following the instructions listed above.

If you enroll in these plans and do not choose a PCP one will be chosen for you and the provider number will be on your new ID cards for you and all dependents listed below. If you have questions about the TRS-ActiveCare Primary or TRS-ActiveCare Primary+ plans, please call your Personal Health Guide at (866) 355-5999.

Blue Essentials HMO participants can call Blue Essentials customer service line at (888)-378-1633.

Primary Care Provider name:

PCP ID #:

**Section 5: Dependent Information (Use additional form for more dependents)**

**SPOUSE** Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Address: \_\_\_\_\_  Same as Employee  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex:  M  F Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Primary Care Physician Name: \_\_\_\_\_  
PCP ID #: \_\_\_\_\_  
Are you covered by other insurance?  Yes  No If yes, Carrier/Plan: \_\_\_\_\_  
Tobacco User:  Yes  No  
If Medicare, select a coverage type:  
 Medicare A and D Primary  Medicare D Primary  Medicare B Primary  
 Medicare A, B and D Primary  Medicare A Primary  Medicare Unknown  
 Medicare B and D Primary  Medicare A and B Primary  Other Coverage

**CHILD** Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
 Child  Grandchild  Disabled  Other  Tobacco user (\*required for children 18 and older)  
Address: \_\_\_\_\_  Same as Employee  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex:  M  F Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Primary Care Physician Name: \_\_\_\_\_  
PCP ID #: \_\_\_\_\_  
Are you covered by other insurance?  Yes  No If yes, Carrier/Plan: \_\_\_\_\_  
If Medicare, select a coverage type:  
 Medicare A and D Primary  Medicare D Primary  Medicare B Primary  
 Medicare A, B and D Primary  Medicare A Primary  Medicare Unknown  
 Medicare B and D Primary  Medicare A and B Primary  Other Coverage

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 Child  Grandchild  Disabled  Other  Tobacco user (\*required for children 18 and older)  
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City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex:  M  F Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Primary Care Physician Name: \_\_\_\_\_  
PCP ID #: \_\_\_\_\_  
Are you covered by other insurance?  Yes  No If yes, Carrier/Plan: \_\_\_\_\_  
If Medicare, select a coverage type:  
 Medicare A and D Primary  Medicare D Primary  Medicare B Primary  
 Medicare A, B and D Primary  Medicare A Primary  Medicare Unknown  
 Medicare B and D Primary  Medicare A and B Primary  Other Coverage

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 Child  Grandchild  Disabled  Other  Tobacco user (\*required for children 18 and older)  
Address: \_\_\_\_\_  Same as Employee  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex:  M  F Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Primary Care Physician Name: \_\_\_\_\_  
PCP ID #: \_\_\_\_\_  
Are you covered by other insurance?  Yes  No If yes, Carrier/Plan: \_\_\_\_\_  
If Medicare, select a coverage type:  
 Medicare A and D Primary  Medicare D Primary  Medicare B Primary  
 Medicare A, B and D Primary  Medicare A Primary  Medicare Unknown  
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**CHILD** Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
 Child  Grandchild  Disabled  Other  Tobacco user (\*required for children 18 and older)  
 Address: \_\_\_\_\_  Same as Employee  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex:  M  F Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Primary Care Physician Name: \_\_\_\_\_  
 PCP ID #: \_\_\_\_\_  
 Are you covered by other insurance?  Yes  No If yes, Carrier/Plan: \_\_\_\_\_  
 If Medicare, select a coverage type:  
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 Medicare A, B and D Primary  Medicare A Primary  Medicare Unknown  
 Medicare B and D Primary  Medicare A and B Primary  Other Coverage

**Section 6: Disabled Dependents Over Age 26**

Request for Dependent Child Statement of Disability  
 \* Please note that a Dependent Child Statement of Disability is required for coverage of a disabled child over age 26 and must be **submitted within 31 days** of the child's 26<sup>th</sup> birthday. See your Benefits Administrator for the form, which must be completed in full and submitted to your Benefits Administrator.

**Section 7: Declination of Coverage**

\* This is to certify that the available coverage has been explained to me. I have been given the opportunity to apply for the coverage available to me and my dependents and have voluntarily elected to decline the coverage as elected below.

Name: _____	SSN: _____	<input type="checkbox"/> Employee
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: ____/____/____	<input type="checkbox"/> Other Coverage: _____
Address: _____		
Name: _____	SSN: _____	<input type="checkbox"/> Spouse
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: ____/____/____	<input type="checkbox"/> Other Coverage: _____
Address: _____ <input type="checkbox"/> Same as Employee		
Name: _____	SSN: _____	<input type="checkbox"/> Child
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: ____/____/____	<input type="checkbox"/> Other Coverage: _____
Address: _____ <input type="checkbox"/> Same as Employee		
Name: _____	SSN: _____	<input type="checkbox"/> Child
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: ____/____/____	<input type="checkbox"/> Other Coverage: _____
Address: _____ <input type="checkbox"/> Same as Employee		
Name: _____	SSN: _____	<input type="checkbox"/> Child
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: ____/____/____	<input type="checkbox"/> Other Coverage: _____
Address: _____ <input type="checkbox"/> Same as Employee		

**Section 8: Coverage Conditions**

I am eligible to participate in the coverage(s) offered by the TRS-ActiveCare program which is administered by Blue Cross and Blue Shield of Texas (BCBSTX), a Division of Health Care Service Corporation Health, with HMO benefits provided by Baylor, Scott and White Health Plan and Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation Health Plans. On behalf of myself and any dependents listed, I apply for those coverage(s) for which I am eligible.

- If I am enrolling a grandchild, 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 support, that neither of the children's natural parents resides in my household, and that I have the legal right to make decisions regarding the child's medical care.

Only those coverage(s) and amount for which I am eligible will be available to me. I understand that if my coverage requests are accepted, the coverage(s) will become effective in accordance with the provisions of the TRS-ActiveCare program.

I understand that by enrolling for coverage 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 by declining TRS-ActiveCare coverage now or by terminating 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 provided in this enrollment 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 Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_