TRS

HEALTH

INSURANCE

APPLICATION

GREEN IS ENROLL

BLUE IS DECLINE

TRS ActiveCare

Enroll

Enrollment, Change and Declination Form

ELIGIBILTY: 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

☐ Annual Enrollment ☐ New Employee ☐ Add Dependent ☐ Special Enrollment

☐ For New Employee (check one): ☐ Effective on Actively at Work ☐ Effective 1st day of month following

Life Event Date: __/__/____ ☐ Marriage ☐ Court Order ☐ Birth/Adoption ☐ Loss of Coverage ☐ Other:

For District Use Only

TRS District #

Actively at Work Date:

Effective/Change Date:

Change Only:
☐ Name
☐ Address
☐ Plan/Coverage

Decline Coverage:
☐ Yes (Complete Section 6)
☐ N/A

Effective Date of Change/Cancel
____/____/_____

Cancel Employee
☐ Death
☐ Loss of Eligibility
☐ Retirement/Terminated
☐ Non-Payment
☐ Other: _____

Cancel Dependent
☐ Divorce
☐ Death
☐ Loss of Eligibility
☐ Dropped Coverage
☐ Other: _____

Employer Approval:
_____

Were you covered by another district? ☐ Yes ☐ No
If so, which: _____

SECTION 2: EMPLOYEE INFORMATION

Last Name: | First Name: | MI: | Social Security #:

Mailing Address: | City: | State: | Zip:

Alternative Address: | City: | State: | Zip:

Home Phone Number: | Work Phone Number: | Work Email:

Date of Birth: | Sex: ☐ M ☐ F | Language: ☐ English ☐ Spanish | Tobacco user: ☐ Yes ☐ No

Do you have a disability affecting your ability to communicate or read? ☐ Yes (Please complete Section 8) ☐ No

Is the Employee Covered By Other Insurance? ☐ Yes Carrier/Plan: ☐ No

Is the Employee Covered by Medicare? ☐ Yes ☐ Part A ☐ Part B ☐ Part C ☐ Part D Effective: ☐ No

Reason for Medicare Coverage: ☐ Entitlement Age ☐ Disability ☐ End Stage Renal Disease (ESRD)

SECTION 3: COVERAGE SELECTION (Please select a Plan of Coverage – Plan or HMO - and Coverage Type)

Plan Selection: ☐ ActiveCare 1-HD ☐ ActiveCare Select ~~☐ ActiveCare Kelsey Select~~

HMO Selection: ~~☐ FirstCare Health Plans~~ ☐ Scott & White Health Plan ~~☐ Blue Essentials Access Plan (formerly Allegiance Health Plan)~~

Coverage Type Selected: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

SECTION 4: DEPENDENT INFORMATION (Use additional form for additional dependents)

SPOUSE Last Name: | First Name: | MI:

Street Address: ☐ Same as Employee

City: | State: | Zip: | Phone Number:

Sex: ☐ M ☐ F | Date of Birth: | Social Security #: | Tobacco user: ☐ Yes ☐ No

Other Insurance: ☐ Yes. Carrier/Plan ☐ No ☐ Medicare: ☐ Part A ☐ Part B ☐ Part C ☐ Part D

CHILD Last Name: | First Name: | MI:

☐ Child ☐ Grandchild ☐ Disabled | Tobacco user: ☐ Yes ☐ No * required for children 18 and older

Street Address: ☐ Same as Employee

City: | State: | Zip Code: | Phone Number:

Date of Birth: | Social Security #: | Sex: ☐ M ☐ F

Other Insurance: ☐ Yes. Carrier/Plan ☐ No ☐ Medicare: ☐ Part A ☐ Part B ☐ Part C ☐ Part D

CHILD Last Name: | First Name: | MI:

☐ Child ☐ Grandchild ☐ Disabled | Tobacco user: ☐ Yes ☐ No * required for children 18 and older

Street Address: ☐ Same as Employee

City: | State: | Zip Code: | Phone Number:

Date of Birth: | Social Security #: | Sex: ☐ M ☐ F

Other Insurance: ☐ Yes. Carrier/Plan ☐ No ☐ Medicare: ☐ Part A ☐ Part B ☐ Part C ☐ Part D

PLEASE CONTINUE ON NEXT PAGE

CHILD Last Name:	First Name:	MI:
☐Child ☐Grandchild ☐Disabled	Tobacco user: ☐ Yes ☐ No	* required for children 18 and older
Street Address:		☐Same as Employee
City:	State:	Zip Code:	Phone Number:
Date of Birth:	Social Security #:	Sex: ☐M ☐F
Other Insurance: ☐Yes, Carrier/Plan	☐No ☐Medicare: ☐Part A ☐Part B ☐Part C ☐Part D	

CHILD Last Name:	First Name:	MI:
☐Child ☐Grandchild ☐Disabled	Tobacco user: ☐ Yes ☐ No	* required for children 18 and older
Street Address:		☐Same as Employee
City:	State:	Zip Code:	Phone Number:
Date of Birth:	Social Security #:	Sex: ☐M ☐F:
Other Insurance: ☐Yes, Carrier/Plan	☐No ☐Medicare: ☐Part A ☐Part B ☐Part C ☐Part D	

SECTION 5: DISABLED DEPENDENTS OVER AGE 26

☐Request for Continuation of Coverage for Handicapped Child form and Attending Physician's Statement

Please note that a Request for Continuation of Coverage for Handicapped Child form and Attending Physician's Statement are required for coverage of a disabled child over age 26. See your Benefits Administrator for the forms, which must be completed in full and submitted to your Benefits Administrator.

SECTION 6: 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:	☐Employee	Reason:	☐Other Coverage	☐Other
Gender: ☐F ☐M	Date of Birth:	Address:			☐same as employee
Name:	SSN	☐Spouse	Reason	☐Other Coverage	☐Other:
Gender: ☐F ☐M	Date of Birth:	Address:			☐same as employee
Name	SSN:	☐Child	Reason:	☐Other Coverage	☐Other:
Gender: ☐F ☐M	Date of Birth:	Address:			☐same as employee
Name:	SSN	☐Child	Reason	☐Other Coverage	☐Other:
Gender: ☐F ☐M	Date of Birth:	Address			☐same as employee
Name:	SSN:	☐Child	Reason:	☐Other Coverage	☐Other:
Gender: ☐F ☐M	Date of Birth	Address:			☐same as employee
Name:	SSN:	☐Child	Reason:	☐Other Coverage	☐Other:
Gender: ☐F ☐M	Date of Birth:	Address:			☐same as employee

SECTION 7: 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) offered by the TRS-ActiveCare program which is administered by Aetna, with HMO benefits provided by SHA, L.L.C. dba FirstCare Health Plan, 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 on their Enrollment Application and Change Form, I apply for those coverage(s) for which I am eligible.
  - If I am enrolling a grandchild in Section 4, 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 4, 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 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 amount 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 or the TRS-ActiveCare program.
- I understand that by enrolling for coverage with Employer named in the 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 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 given on the 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 Signature: _____ Date: _____

SECTION 8: SPECIAL NOTES REGARDING MY ENROLLMENT (Please indicate any special information regarding my enrollment for Aetna, Caremark or my selected HMO)

TRS ActiveCare

Decline

Enrollment, Change and Declination Form

ELIGIBILTY: 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

☐ Annual Enrollment ☐ New Employee ☐ Add Dependent ☐ Special Enrollment

☐ **For New Employee** (check one): ☐ Effective on Actively at Work ☐ Effective 1st day of month following

Life Event Date: __/__/____ ☐ Marriage ☐ Court Order ☐ Birth/Adoption ☐ Loss of Coverage ☐ Other:

Change Only:
☐ Name
☐ Address
☐ Plan/Coverage

Decline Coverage:
☐ Yes (Complete Section 6)
☐ N/A

Effective Date of Change/Cancel
____/____/_____

Cancel Employee
☐ Death
☐ Loss of Eligibility
☐ Retirement/Terminated
☐ Non-Payment
☐ Other: _____

Cancel Dependent
☐ Divorce
☐ Death
☐ Loss of Eligibility
☐ Dropped Coverage
☐ Other: _____

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

Employer Approval: _____

Were you covered by another district? ☐ Yes ☐ No
If so, which: _____

SECTION 2: EMPLOYEE INFORMATION

Last Name: | First Name: | MI: | Social Security #:

Mailing Address: | City: | State: | Zip:

Alternative Address: | City: | State: | Zip:

Home Phone Number: | Work Phone Number: | Work Email:

Date of Birth: | Sex: ☐ M ☐ F | Language: ☐ English ☐ Spanish | Tobacco user: ☐ Yes ☐ No

Do you have a disability affecting your ability to communicate or read? ☐ Yes (Please complete Section 8) ☐ No

Is the Employee Covered By Other Insurance? ☐ Yes Carrier/Plan: ☐ No

Is the Employee Covered by Medicare? ☐ Yes ☐ Part A ☐ Part B ☐ Part C ☐ Part D Effective: ☐ No

Reason for Medicare Coverage: ☐ Entitlement Age ☐ Disability ☐ End Stage Renal Disease (ESRD)

SECTION 3: COVERAGE SELECTION (Please select a Plan of Coverage – Plan or HMO – and Coverage Type)

Plan Selection: ☐ ActiveCare 1 HD ☐ ActiveCare Select ~~☐ ActiveCare Kelsey Select~~

HMO Selection: ~~☐ FirstCare Health Plans~~ ☐ Scott & White Health Plan ~~☐ Blue Essentials Access Plan (Form C, Allegiance Plans)~~

Coverage Type Selected: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

SECTION 4: DEPENDENT INFORMATION (Use additional form for additional dependents)

SPOUSE Last Name: | First Name: | MI:

Street Address: ☐ Same as Employee

City: | State: | Zip: | Phone Number:

Sex: ☐ M ☐ F | Date of Birth: | Social Security #: | Tobacco user: ☐ Yes ☐ No

Other Insurance: ☐ Yes. Carrier/Plan ☐ No ☐ Medicare: ☐ Part A ☐ Part B ☐ Part C ☐ Part D

CHILD Last Name: | First Name: | MI:

☐ Child ☐ Grandchild ☐ Disabled | Tobacco user: ☐ Yes ☐ No * required for children 18 and older

Street Address: ☐ Same as Employee

City: | State: | Zip Code: | Phone Number:

Date of Birth: | Social Security #: | Sex: ☐ M ☐ F

Other Insurance: ☐ Yes. Carrier/Plan ☐ No ☐ Medicare: ☐ Part A ☐ Part B ☐ Part C ☐ Part D

CHILD Last Name: | First Name: | MI:

☐ Child ☐ Grandchild ☐ Disabled | Tobacco user: ☐ Yes ☐ No * required for children 18 and older

Street Address: ☐ Same as Employee

City: | State: | Zip Code: | Phone Number:

Date of Birth: | Social Security #: | Sex: ☐ M ☐ F

Other Insurance: ☐ Yes. Carrier/Plan ☐ No ☐ Medicare: ☐ Part A ☐ Part B ☐ Part C ☐ Part D

PLEASE CONTINUE ON NEXT PAGE

CHILD Last Name:	First Name:	MI:
☐Child ☐Grandchild ☐Disabled	Tobacco user: ☐ Yes ☐ No	* required for children 18 and older
Street Address:		☐Same as Employee
City:	State: Zip Code:	Phone Number:
Date of Birth:	Social Security #:	Sex: ☐M ☐F
Other Insurance: ☐Yes. Carrier/Plan	☐No ☐Medicare: ☐Part A ☐Part B	☐Part C ☐Part D

CHILD Last Name:	First Name:	MI:
☐Child ☐Grandchild ☐Disabled	Tobacco user: ☐ Yes ☐ No	* required for children 18 and older
Street Address:		☐Same as Employee
City:	State: Zip Code:	Phone Number:
Date of Birth:	Social Security #:	Sex: ☐M ☐F:
Other Insurance: ☐Yes. Carrier/Plan	☐No ☐Medicare: ☐Part A ☐Part B	☐Part C ☐Part D

SECTION 5: DISABLED DEPENDENTS OVER AGE 26 ☐Request for Continuation of Coverage for Handicapped Child form and Attending Physician's Statement

Please note that a Request for Continuation of Coverage for Handicapped Child form and Attending Physician's Statement are required for coverage of a disabled child over age 26. See your Benefits Administrator for the forms, which must be completed in full and submitted to your Benefits Administrator.

SECTION 6: 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:	☐Employee	Reason:	☐Other Coverage	☐Other
Gender: ☐F ☐M	Date of Birth:	Address:			☐same as employee
Name:	SSN:	☐Spouse	Reason:	☐Other Coverage	☐Other:
Gender: ☐F ☐M	Date of Birth:	Address:			☐same as employee
Name:	SSN:	☐Child	Reason:	☐Other Coverage	☐Other:
Gender: ☐F ☐M	Date of Birth:	Address:			☐same as employee
Name:	SSN:	☐Child	Reason:	☐Other Coverage	☐Other:
Gender: ☐F ☐M	Date of Birth:	Address:			☐same as employee
Name:	SSN:	☐Child	Reason:	☐Other Coverage	☐Other:
Gender: ☐F ☐M	Date of Birth:	Address:			☐same as employee
Name:	SSN:	☐Child	Reason:	☐Other Coverage	☐Other:
Gender: ☐F ☐M	Date of Birth:	Address:			☐same as employee

SECTION 7: 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) offered by the TRS-ActiveCare program which is administered by Aetna, with HMO benefits provided by SHA, L.L.C. dba FirstCare Health Plan, 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 on their Enrollment Application and Change Form, I apply for those coverage(s) for which I am eligible.

  If I am enrolling a grandchild in Section 4, 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 4, 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 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 amount 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 or the TRS-ActiveCare program.
- I understand that by enrolling for coverage with Employer named in the 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 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 given on the 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 Signature: ______________________________ Date: ______________

SECTION 8: SPECIAL NOTES REGARDING MY ENROLLMENT (Please indicate any special information regarding my enrollment for Aetna, Caremark or my selected HMO)

Faith Family Academy Healthcare Waiver/Declination Form

Do you want to decline medical coverage for yourself? ☐

Do you want to decline medical coverage for your spouse? ☐

Do you want to decline medical coverage for your dependent children? ☐

For District Use Only

Date of Hire ____/____/____

Insurance Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ____/____/____ Social Security Number: _____ Sex: Male or Female

Physical Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Cell Phone: _____

Do you have a disability affecting your ability to communicate or read? Yes or No

Are you covered by any other health insurance company? Yes or No

Are you covered by (Please Circle): Medicare Medicaid CHIP COBRA Other: _____

Do you have health insurance through a spouses or parents employer? Yes or No

Do you have health insurance through a private policy? Yes or No

Do you have health insurance through the Exchange (Marketplace) with a subsidy? Yes or No

Do you have health insurance through the Exchange (Marketplace) with no subsidy? Yes or No

I do not have health insurance (check this box if applicable): ☐

Declination of Dependent Coverage

Spouse Name: _____

Other Coverage? Yes or No

Dependent Child Name: _____

Other Coverage? Yes or No

Dependent Child Name: _____

Other Coverage? Yes or No

Dependent Child Name: _____

Other Coverage? Yes or No

Special Enrollment Notice and Certification –Please review and sign below if you wish to waive coverage.

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependent, if any. I am declining enrollment as indicated above. I understand that, if I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose eligibility for that other coverage (or if the employers stops contributing towards my or my eligible dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing towards the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

I understand that the offer of these plans by employer meets both the 60% Minimum Value and is deemed affordable. This means that I will not be eligible to receive subsidy for a plan in the Exchange. I may still purchase a plan from the Exchange without a subsidy and I may eligible for Medicaid.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

I understand that in order to request special enrollment or obtain more information, I should contact my group administrator.

_____ _____

Employee Signature Date