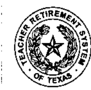

TRS-ActiveCare
TEACHER RETIREMENT SYSTEM OF TEXAS

Please print in blue or black ink.

Enrollment Application and Change Form

Group Number 085000

www.trs.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 MM DD YYYY
Effective Date of Coverage MM DD YYYY
Employer Verification Signature

SECTION 2 — PLEASE TELL US ABOUT YOURSELF (Complete even if declining coverage)

❑ Male ❑ Female	❑ Married ❑ Single	Last Name	First Name	Middle Initial

Birth Date (MM DD YYYY)	Social Security Number	Work Phone Number ( )	Home Phone Number ( )

Mailing Address	City	State	ZIP

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:

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.

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 (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** ❑ **ActiveCare 2** ❑ **ActiveCare 3**

HMO: ❑ **FirstCare** ❑ **Legacy Health Solutions** ❑ **Mercy Health Plans** ❑ **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 :

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.