



Enrollment Application and Change Form



ELIGIBILITY: Are you an active employee and making monthly contributions to TRS? ... (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
Special Enrollment Event Date, Marriage, Court Order, Birth/Adoption, Loss of Coverage, Other
Change Only, Decline Coverage, Cancel Employee, Cancel Dependent

SECTION 2: EMPLOYEE INFORMATION
Last Name, First Name, MI, Social Security #, Mailing Address, City, State, Zip, Home Phone Number, Cell Phone Number, Email, Date of Birth, Sex, Language, Ethnicity

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

SECTION 4: DEPENDENT INFORMATION (Use additional form for additional dependents)
SPOUSE: Last Name, First Name, MI, Street Address, City, State, Zip, Phone Number, Sex, Date of Birth, Social Security #, Other Insurance
CHILD: Last Name, First Name, MI, Street Address, City, State, Zip, Phone Number, Date of Birth, Social Security #, Sex, Other Insurance

PLEASE CONTINUE ON NEXT PAGE

CHILD Last Name:		First Name:			MI:
<input type="checkbox"/> Natural/Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Disabled <input type="checkbox"/> Other					
Street Address: <input type="checkbox"/> Same as Employee					
City:		State:	Zip Code:	Phone Number:	
Date of Birth:		Social Security #:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Other Insurance: <input type="checkbox"/> Yes. Carrier/Plan <input type="checkbox"/> No <input type="checkbox"/> Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part C <input type="checkbox"/> Part D					
CHILD Last Name:		First Name:			MI:
<input type="checkbox"/> Natural/Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Disabled <input type="checkbox"/> Other					
Street Address: <input type="checkbox"/> Same as Employee					
City:		State:	Zip Code:	Phone Number:	
Date of Birth:		Social Security #:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Other Insurance: <input type="checkbox"/> Yes. Carrier/Plan <input type="checkbox"/> No <input type="checkbox"/> Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part C <input type="checkbox"/> Part D					
SECTION 5: DISABLED DEPENDENTS OVER AGE 26 <input type="checkbox"/> 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:	<input type="checkbox"/> Employee	Reason:	<input type="checkbox"/> Other Coverage	<input type="checkbox"/> Other:
Name:		<input type="checkbox"/> Spouse	Reason:	<input type="checkbox"/> Other Coverage	<input type="checkbox"/> Other:
Name:		<input type="checkbox"/> Child	Reason:	<input type="checkbox"/> Other Coverage	<input type="checkbox"/> Other:
Name:		<input type="checkbox"/> Child	Reason:	<input type="checkbox"/> Other Coverage	<input type="checkbox"/> Other:
Name:		<input type="checkbox"/> Child	Reason:	<input type="checkbox"/> Other Coverage	<input type="checkbox"/> Other:
Name:		<input type="checkbox"/> Child	Reason:	<input type="checkbox"/> Other Coverage	<input type="checkbox"/> Other:
SECTION 7: COVERAGE CONDITIONS					
<ul style="list-style-type: none"> • 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 Allegian Insurance Company dba Allegian 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. <ul style="list-style-type: none"> o 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. o 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)