Initial Enrollment Application for Medicare Eligible Retirees and Dependents for All Plan Options

TRS700MDV-OL (12-25)

PO Box 149676
Austin, Texas 78714-0185
(800) 223-8778
www.trs.texas.gov

This application should be completed by the TRS retiree enrolling in TRS-Care medical and prescription drug coverage, TRS-Care dental and/or vision coverage

Read all the information provided in your *Initial Enrollment packet and the Instructions for Initial Enrollment Application for Medicare Eligible Retirees and/or Dependents for All Plan Options* (TRS700MDV) before completing this application. Please do not skip any sections unless advised to do so. There are required fields throughout this document. Submitting an incomplete document could cause a delay in enrollment. Be advised that all future plan options are subject to change, for example, benefits, premiums, and/or member cost-share may change each year.

Complete the following sections to enroll in TRS-Care coverage(s):

Sections B and C are only required if you are adding a spouse or dependent children.

- **SECTION A –** Retiree Information
- **SECTION B –** Eligible Spouse Information
- **SECTION C –** Eligible Child(ren) Information
- **SECTION D –** Acknowledgment and Acceptance
  Enrollment applications must include all required signature(s) to be accepted.

SECTION A – RETIREE INFORMATION

Name _____ TRS Participant ID or Social Security Number _____
(First Name, Middle Initial, Last Name, Suffix)

Gender ☐ Male ☐ Female Date of Birth _____ Phone Number _____

Mailing Address _____ City _____ State _____ Zip _____

If the mailing address above is a PO Box, please provide your physical address.

Physical Address _____ City _____ State _____ Zip _____

Email Address _____

Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed

Current or last TRS covered employer (e.g., district, charter school, or similar entity) _____

Please select the month and year you would like your TRS-Care coverage to begin.

You may defer the start date of your TRS-Care coverage up to three months after your retirement date.

Month _____ Year _____

TRS-Care coverage begins on the first day of the month. If TRS receives your application after your requested TRS-Care coverage start date, your coverage will start on the first day of the month following receipt by TRS. TRS must be able to verify your Medicare Part B enrollment prior to enrolling you in the TRS-Care Medicare Advantage medical plan.

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Retiree Coverage Selection: *Select each coverage you are enrolling in.*

☐ **Medical/Prescription**	☐ **Dental**	☐ **Vision**

Retiree Medicare Information

You must be enrolled in Medicare Part B to be eligible to enroll in the ***TRS-Care Medicare Advantage*** *medical and prescription drug plan. If you are not eligible for Medicare, you will be enrolled in the* ***TRS-Care Standard*** *medical and prescription drug plans.*

Are you enrolled in Medicare?

☐ Yes - Proceed below

☐ No - Proceed to **SECTION B**

If yes, what is your Medicare Number? _____

What part(s) of Medicare do you have?

☐ Medicare Part A - Effective Date _____

☐ Medicare Part B - Effective Date _____

Please see the General Information Section in the Instructions (TRS700MDVIN) as to why TRS is requesting the following race and ethnicity information. **Answering these questions is voluntary.** You will not be denied coverage if you do not fill them out.

Ethnicity: Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

☐ Mexican, Mexican American, Chicano/a	☐ Cuban	☐ I choose not to answer
☐ Not of Hispanic, Latino/a or Spanish Origin	☐ Puerto Rican	☐ Another Hispanic, Latino or Spanish Origin

Race: What is your race? Select all that apply.

☐ American Indian or Alaska Native	☐ Asian Indian	☐ Black or African American
☐ Chinese	☐ Filipino	☐ Guamanian or Chamorro
☐ Japanese	☐ Korean	☐ Native Hawaiian
☐ Other Asian	☐ Other Pacific Islander	☐ Samoan
☐ Vietnamese	☐ White	☐ I choose not to answer

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SECTION B – ELIGIBLE SPOUSE INFORMATION
Only complete this section if you want to enroll your spouse.

Spouse's Name _____ Gender ☐ Male ☐ Female
(First Name, Middle Initial, Last Name, Suffix)

Date of Birth _____ Social Security Number _____

Spouse Coverage Selection: *Select each coverage your spouse is enrolling in.*
An eligible spouse can only enroll in a coverage if the retiree is enrolling in the respective coverage.

☐ **Medical/Prescription**	☐ **Dental**	☐ **Vision**

Spouse Medicare Information
*If your spouse is enrolled in Medicare, he/she will be enrolled in the **TRS-Care Medicare Advantage** medical and prescription drug plan. If he/she is not Medicare eligible, your spouse will be enrolled in the **TRS-Care Standard** medical and prescription drug plans.*

Is your spouse enrolled in Medicare?

☐ Yes - Proceed below

☐ No - Proceed to **Section C**

If yes, what is your spouse's Medicare Number? _____

What part(s) of Medicare does your spouse have?

☐ Medicare Part A - Effective Date _____

☐ Medicare Part B - Effective Date _____

Please see the General Information Section in the Instructions (TRS700MDVIN) as to why TRS is requesting the following race and ethnicity information. **Answering these questions is voluntary.** Your spouse will not be denied coverage if you do not fill them out.

Ethnicity: Is your Spouse Hispanic, Latino/a, or Spanish origin? Select all that apply.

☐ Mexican, Mexican American, Chicano/a	☐ Cuban	☐ I choose not to answer
☐ Not of Hispanic, Latino/a or Spanish Origin	☐ Puerto Rican	☐ Another Hispanic, Latino or Spanish Origin

Race: What is your Spouse's race? Select all that apply.

☐ American Indian or Alaska Native	☐ Asian Indian	☐ Black or African American
☐ Chinese	☐ Filipino	☐ Guamanian or Chamorro
☐ Japanese	☐ Korean	☐ Native Hawaiian
☐ Other Asian	☐ Other Pacific Islander	☐ Samoan
☐ Vietnamese	☐ White	☐ I choose not to answer

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SECTION C – ELIGIBLE CHILD(REN) INFORMATION

Only complete this section if you want to enroll a dependent child age 25 or under. To enroll more than one child, make additional copies of this section. *Contact TRS Health for the appropriate forms if you have a child that has a mental disability or is physically incapacitated, and you would like to add that child to TRS-Care.*

Child's Name _____ Gender ☐ Male ☐ Female
(First Name, Middle Initial, Last Name, Suffix)

Date of Birth _____ Social Security Number _____

Relationship to Retiree: ☐ Natural ☐ Stepchild ☐ Grandchild ☐ Adopted ☐ Foster ☐ Guardianship ☐ Other

Child Coverage Selection: *Select each coverage your child is enrolling in.*
An eligible child can only enroll in a coverage if the retiree is enrolling in the respective coverage.
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☐ **Medical/Prescription**	☐ **Dental**	☐ **Vision**

Child Medicare Information
*If your child is enrolled in Medicare, he/she will be enrolled in the **TRS-Care Medicare Advantage** medical and prescription drug plan. If he/she is not Medicare eligible, your child will be enrolled in the **TRS-Care Standard** medical and prescription drug plans.*

Is your child enrolled in Medicare?

☐ Yes - Proceed below ☐ No - Proceed to **Section D**

If yes, what is your child's Medicare Number? _____

What part(s) of Medicare does your child have?

☐ Medicare Part A - Effective Date _____

☐ Medicare Part B - Effective Date _____

Please see the General Information Section in the Instructions (TRS700MDVIN) as to why TRS is requesting the following race and ethnicity information. **Answering these questions is voluntary.** Your child will not be denied coverage if you do not fill them out.

Ethnicity: Is your Child Hispanic, Latino/a, or Spanish origin? Select all that apply.

☐ Mexican, Mexican American, Chicano/a	☐ Cuban	☐ I choose not to answer
☐ Not of Hispanic, Latino/a or Spanish Origin	☐ Puerto Rican	☐ Another Hispanic, Latino or Spanish Origin

Race: What is your Child's race? Select all that apply.

☐ American Indian or Alaska Native	☐ Asian Indian	☐ Black or African American
☐ Chinese	☐ Filipino	☐ Guamanian or Chamorro
☐ Japanese	☐ Korean	☐ Native Hawaiian
☐ Other Asian	☐ Other Pacific Islander	☐ Samoan
☐ Vietnamese	☐ White	☐ I choose not to answer

TRS CARE
TEACHER RETIREMENT SYSTEM OF TEXAS

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SECTION D – MEDICARE ADVANTAGE ACKNOWLEDGMENT DISCLOSURES – READ THIS SECTION CAREFULLY. (SIGNATURE(S) REQUIRED)

By completing this enrollment application, I agree to the following: The TRS-Care Medicare Advantage plan is a UHC Group Medicare Advantage (PPO) Plan contract with the Federal government. I will need to keep my Medicare Part B in effect. I can only be in one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. I understand that the TRS-Care Medicare Prescription Drug Plan is considered creditable coverage under Medicare. Creditable coverage means that on average, TRS-Care prescription coverage is equal to or better than the Medicare Part D coverage provided directly from Medicare. Having creditable coverage allows me to enroll in a Medicare Part D plan during future annual Medicare Part D plan enrollments without a penalty (higher premium) from Medicare. Enrollment in this TRS-Care Medicare Advantage, UHC Group Medicare Advantage (PPO) plan is generally for the entire year. However, once I enroll, per TRS-Care Rules, I may leave this plan at any time by completing the required TRS-Care document to terminate coverage.

The TRS-Care Medicare Advantage, UHC Group Medicare Advantage (PPO) is a nationwide network. I can access providers in the United States. Therefore, If I move out of the TRS-Care Medicare Advantage, UHC Group Medicare Advantage (PPO) plan service area, I may keep this plan or choose another plan outside of TRS-Care. Once I am a participant of the TRS-Care Medicare Advantage, UHC Group Medicare Advantage (PPO) plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from UnitedHealthcare (UHC) when I get it to know which rules I must follow to get coverage with this TRS-Care Medicare Advantage, UHC Group Medicare Advantage (PPO) plan. I understand that people with Original Medicare aren't usually covered under Medicare while out of the country, except for limited coverage near the U.S. border. I may also be disenrolled if I do not pay any applicable plan premiums within the grace period. The effective date of disenrollment is in accordance with Federal requirements. Once I am a participant of the TRS-Care Medicare Advantage, UHC Group Medicare Advantage (PPO) plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from UnitedHealthcare (UHC) when I get it to know which rules I must follow to get coverage with this TRS-Care Medicare Advantage, UHC Group Medicare Advantage (PPO) plan. I understand that people with Original Medicare aren't usually covered under Medicare while out of the country, except for limited coverage near the U.S. border. I may also be disenrolled if I do not pay any applicable plan premiums within the grace period. The effective date of disenrollment is in accordance with Federal requirements. I understand that disenrolling from the TRS-Care medical and prescription drug plans terminates coverage for myself and any covered dependents. TRS-Care has limited opportunities to re-enroll in medical and prescription drug plans.

TRS-Care Medicare Advantage, UHC Group Medicare Advantage (PPO) plan: I understand that beginning on the date TRS-Care Medicare Advantage, UHC Group Medicare Advantage (PPO) plan coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out of area dialysis services. I understand that I can go to doctors, specialists, or hospitals in or out-of-network. I understand that providers must be licensed and eligible to receive payment under the Federal Medicare program and agree to accept the TRS-Care Medicare Advantage, UHC Group Medicare Advantage (PPO) plan. I also understand that I may have to pay more for services that I receive out-of-network when the provider is not licensed and not eligible to receive payment under the Federal Medicare program. Services authorized by the TRS-Care Medicare Advantage, UHC Group Medicare Advantage (PPO) plan and other services contained in my TRS-Care Medicare Advantage, UHC Group Medicare Advantage (PPO) plan Evidence of Coverage document (also known as the member contract or subscriber agreement) will be covered. Without authorization, when required by UHC, **neither Medicare nor the TRS-Care Medicare Advantage Plan will pay for the services.**

I have been advised not to cancel or terminate any supplemental insurance I currently have until I receive written notification of my confirmed effective date from UHC.

I understand that the providers in the UHC network are independent contractors in private practice and are neither employees nor agents of UHC or its affiliates.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with UHC's Medicare Advantage plan, he/she may be paid based on my enrollment in the Medicare Advantage plan.

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Release of information: By joining this TRS-Care Medicare Advantage, UHC Group Medicare Advantage (PPO) plan, I acknowledge that UHC or its affiliates will release my information to Medicare and others as is necessary for treatment, payment of claims, and health care operations. I also acknowledge that TRS-Care Medicare Advantage, UHC Group Medicare Advantage (PPO) plan will release my information, including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual, this certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

TRS-Care Medicare Advantage PPO is a Medicare Advantage plan with a Medicare contract. Enrollment in this UHC plan depends on contract renewal. This information is not a complete description of benefits. (Contact UHC at (866) 347-9507 for more information. Limitations, copayments, and restrictions may apply) I understand that benefits, premiums, and/or member cost-share may change each year. I must continue to pay my Medicare Part B premium.

I acknowledge receipt of the instructions for completing this form. I acknowledge that the information applies to all plans, TRS-Care Medicare Advantage, TRS-Care Standard, TRS-Care Dental, and TRS-Care Vision, which I have applied to enroll in for myself and eligible dependents. I certify that the information on this form is true and complete to the best of my knowledge. I understand that giving false information on this form may result in loss of coverage.

Information collected in this form includes my telephone number and my cell phone number, if provided. I understand that this information will also be provided to third parties in connection with health plan administration. I consent to calls or texts at these numbers and I understand that the calls I receive could be automated. **I understand that I can cancel this consent to receiving calls and texts at these numbers at any time** without affecting my eligibility for benefits, enrollment and coverage, and without affecting my ability to get treatment. Upon request, TRS will provide me with the identity of the third parties that may be communicating with me at these phone numbers. I also understand that data use charges and rates from cellular carriers may apply.

I authorize the Teacher Retirement System of Texas (TRS) to withhold from my monthly annuity and remit to TRS-Care any amount necessary to cover my share of the cost of the coverage. If the amount of my annuity is not sufficient to cover the cost of the selected coverage, or if I am not receiving a monthly annuity, I understand that TRS-Care or the TRS-Care administrator will bill me, and I understand that it is my responsibility to send payment on a timely basis. I understand that failure to pay my full premium amount timely may result in termination of my TRS-Care coverage and termination of coverage for any of my eligible dependents.

I understand that a TRS service retiree or a TRS disability retiree who meets TRS-Care eligibility, may apply for health care coverage under TRS-Care. I understand that the individuals that I am enrolling as dependents must meet the TRS-Care eligibility criteria for dependents as defined by TRS-Care. **I understand that TRS-Care may request documentation to support their eligibility at any time.** Failure to provide supporting documentation when requested may result in the termination of any of the TRS-Care plans in which I and my dependent(s) are enrolled. **I understand that a service retiree under the TRS retirement plan who is eligible for another state group health plan as an employee or retiree of either the State of Texas or a Texas public college or university is not eligible to participate in TRS-Care. I agree to notify TRS-Care immediately if such eligibility occurs in the future.** I understand that if I am uncertain about whether I am eligible for coverage under TRS-Care, I should contact TRS Health at (888) 237-6762 before signing and submitting this application. I certify that I am, and any dependent that I am enrolling in coverage are eligible to participate in TRS-Care.

I understand that future plan options are subject to change.

I understand this form does not serve as a change of beneficiary of TRS retirement, death, or survivor benefits.

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TRS700MDV-OL (12-25)

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This page must be completed and signed by the Retiree and, if applicable, the Spouse, Child(ren), or Authorized Representatives(s) before returning to TRS.

RETIREE
The following information must be completed and signed by the retiree.

X_____ _____
Signature of Retiree *or Authorized Representative* **Date**

Printed name of Authorized Representative, if applicable _____

If you are the Authorized **Representative**, you must sign above and provide the following information.

Address _____ City _____ State _____ Zip _____

Phone Number _____ Relationship to Enrollee _____

SPOUSE
The following information must be completed and signed by your spouse, if your spouse is also enrolling.

X_____ _____
Signature of Spouse *or Authorized Representative* **Date**

Printed name of Authorized Representative, if applicable _____

If you are the Authorized **Representative**, you must sign above and provide the following information.

Address _____ City _____ State _____ Zip _____

Phone Number _____ Relationship to Enrollee _____

DEPENDENT CHILD
The following information must be completed and signed by your adult child, or legal representative if the child is a minor.
If you have more than one child enrolling in coverage, make additional copies of this section.

X_____ _____
Signature of Dependent Child *or Authorized Representative* **Date**

Printed name of Authorized Representative, if applicable _____

If you are the Authorized **Representative**, you must sign above and provide the following information.

Address _____ City _____ State _____ Zip _____

Phone Number _____ Relationship to Enrollee _____

Instructions Initial Enrollment Application for Medicare Eligible Retirees and Dependents for All Plan Options (TRS700MDVIN)

TRS700MDVIN-OL (12-25)

PO Box 149676
Austin, Texas 78714-0185
(800) 223-8778
www.trs.texas.gov

INITIAL ENROLLMENT APPLICATION – TRS700MDVIN

Please read the TRS-Care information provided in this packet carefully before submitting your application to TRS-Care. You can find more information about TRS-Care in the Health Care Benefits section of the TRS website at www.trs.texas.gov.

Complete the enclosed *Initial Enrollment Application for Medicare Eligible Retirees and Dependents for All Plan Options* (TRS700MDV) and return it to TRS-Health, PO Box 149676, Austin, Texas 78714-0185. You MUST return this application to enroll in TRS-Care. **If you do not want to enroll in TRS-Care at this time, no action is required. Please note that if you do not enroll in TRS-Care medical and pharmacy coverage at this time, your only opportunities to enroll in TRS-Care are with an applicable qualifying life event or when you, the retiree, turn age 65. TRS-Care does offer an annual enrollment period for TRS-Care Dental and TRS-Care Vision. You may elect to make changes to only your dental and vision coverage during the annual enrollment period for TRS-Care Dental and TRS-Care Vision coverage.**

A section on your enrollment form asks for Race and Ethnicity, and the information is optional, and you may choose to opt out of answering. If you provide it, TRS will protect this information and only share it with CMS (the Centers for Medicare and Medicaid Services), which requires this field to be on the form as an option. Their stated goal is to use the data to better understand individuals' needs and eliminate barriers in health care access.

ENROLLMENT PERIOD

For service retirees, you must complete the application and return it to TRS by the last day of the month that is three consecutive calendar months after your effective retirement date or the last day of the month that is three consecutive calendar months following the month in which TRS receives your retirement application (TRS30). In the event that the three calendar months provided allow less than ninety days to return the application, then ninety days shall be provided.

For disability retirees, you must return the application to TRS by the last day of the month that is three consecutive calendar months - but in no event less than 90 days - after the date that your disability retirement is approved by the TRS Medical Board.

You should return your completed TRS700MDV promptly because retroactive changes cannot be made. TRS must receive your application prior to your retirement date for coverage to begin on the first day of the month after your retirement date. If you do not enroll in TRS-Care Standard or TRS-Care Medicare Advantage at this time, your only opportunities to enroll in TRS-Care Standard or TRS-Care Medicare Advantage are with an applicable qualifying life event or when you, the retiree, turn age 65. TRS-Care does offer an annual enrollment period for TRS-Care Dental and TRS-Care Vision. You may elect to make changes to only your dental and vision coverage during the annual enrollment period for TRS-Care Dental and TRS-Care Vision coverage.

EFFECTIVE DATE

If you return your completed TRS700MDV before the end of the applicable enrollment period as described above, you may defer the start date of your TRS-Care coverage up to three months after your effective retirement date. You must write the deferred start date on page 1 of the TRS700MDV, by indicating any of the three months immediately following the month after your retirement date. For example, if your effective retirement date is May 31, you may defer the effective date of your TRS-Care coverage to July 1, August 1, or September 1. TRS-Care coverage begins on the first day of the month.

You cannot defer the effective date of TRS-Care coverage to a date prior to the date upon which TRS-Care receives your application for TRS-Care coverage.

The TRS-Care plan year aligns with the calendar year. Your deductible and out-of-pocket maximum will reset on January 1 of each year, regardless of your initial TRS-Care effective date.

During the applicable enrollment period described above, you may amend your TRS700MDV to change your dependent coverage selections, but not retroactively. Please call TRS Health at (888) 237-6762 with any questions.

PREMIUM PAYMENTS

Monthly contributions to TRS-Care Standard and TRS-Care Medicare Advantage will be based on the individuals covered and your (the retiree) Medicare eligibility.

TRS-Care dental and vision premiums are separate from TRS-Care Standard and TRS-Care Medicare Advantage premiums. Medicare eligibility of the retiree does not impact the premiums for TRS-Care Dental and TRS-Care Vision. Refer to the premium chart on the Health Care Benefits section of the TRS website www.trs.texas.gov.

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INSTRUCTIONS FOR COMPLETING FORM TRS700MDV

COMPLETE ONLY IF YOU ARE ENROLLING IN TRS-CARE

Section A – TRS Retiree Information
You must complete all identifying data including gender, date of birth, telephone number, mailing address, physical address, email address, marital status, and last TRS covered employer. Please complete all remaining sections.

Section B – Eligible Spouse Information
If you want to enroll your eligible spouse, complete all identifying data, including name, social security number, gender, and date of birth. Please complete all remaining sections.

If you are not enrolling your spouse, leave this section blank. If you do not enroll your spouse at this time, you can only enroll your spouse with a future applicable qualifying life event or when you, the retiree, turn age 65.

Section C – Eligible Child(ren) Information
If you want to enroll your eligible child(ren), complete all identifying data, including name, social security number, gender, date of birth, and relationship to you, the retiree. Please complete all remaining sections. If you are enrolling more than one child, make copies of this section to include with the application. If you would like to add a dependent child that is age 26 or older, they must have a mental disability or be physically incapacitated. Contact TRS Health at (888) 237-6762 to request the applicable forms.
If you are not enrolling your child(ren), leave this section blank. If you do not enroll your child(ren) at this time, you can only enroll your child(ren) with a future applicable qualifying life event or when you, the retiree, turn age 65.

Section D – Acknowledgment and Acceptance
Sign and date. Please review and ensure that you understand your coverage as described in the TRS-Care Guide located on the TRS website. By signing this form, you are stating that you understand and agree to the Acknowledgment and Acceptance of the application. You are also verifying that you and any dependents you are enrolling meet the applicable TRS-Care eligibility criteria.

IMPORTANT NOTICES

You are encouraged to consider your options carefully.

PLEASE NOTE: After your initial enrollment period, the ONLY opportunities for you to later enroll in TRS-Care medical coverage or add an eligible dependent to TRS-Care medical coverage, are if there is a future applicable qualifying life event for yourself or an eligible dependent, or when you turn age 65. To later add an eligible dependent, you must also enroll in TRS-Care if you are not already enrolled.

TRS-Care does offer an annual enrollment period for TRS-Care Dental and TRS-Care Vision coverage. You may elect to make changes to only your dental and vision coverage during the annual enrollment period for TRS-Care Dental and TRS-Care Vision coverage.

TRS-Care is a group health benefits program available to eligible public school members who retire under TRS law and rules, surviving spouses, and dependent children of deceased active TRS members and retirees who meet TRS-Care eligibility criteria. You may drop dependent(s) at any time.

Return completed form to:
TRS Health
Teacher Retirement System of Texas
PO Box 149676, Austin, Texas 78714-0185
Telephone (888) 237-6762
Fax (512) 542-6575
www.trs.texas.gov