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

TRS700ADV-OL (04-25)

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 for medical, dental, and/or vision coverage

Please do not skip any sections unless advised to do so. There are required fields and signatures 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.

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) _____

Who do you want to enroll?

☐ Retiree only ☐ Retiree and Spouse ☐ Retiree and Child(ren) ☐ Retiree, Spouse, and Child(ren)

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

Effective date of coverage: _____

Plan Selection – Retiree:		
☐ Medical/Prescription	☐ Dental	☐ Vision

If your **spouse or dependent child** is eligible for Medicare, TRS-Care requires additional information. Please contact TRS Health at (888) 237-6762 for additional information on how to enroll your spouse.

** *If you need to add more children, please make additional copies of the next page* **

For a dependent child(ren) , please complete only if you are enrolling a dependent child age 25 or under, or regardless of age if they have a mental disability or are physically incapacitated.

If your **dependent child(ren)** has a mental disability, is physically incapacitated, and/or is eligible for Medicare, TRS-Care requires additional information. Please contact TRS Health at (888) 237-6762 for additional information on how to enroll your dependent child(ren).

Please complete all sections for yourself and any dependents you are enrolling. A dependent can only enroll in a plan if the retiree or surviving spouse is also enrolled in the respective plan.

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Section B – Spouse Information

First Name, Middle Initial, Last Name, Suffix: ______________________

Date of Birth (MM/DD/YYYY): ______________ Social Security Number: ______________

Relationship to Retiree (See options in instructions): ______________ Gender (M/F): ______

Plan Selection:

☐ Medical/Prescription ☐ Dental ☐ Vision

Section C – Dependent Child(ren) Information

First Name, Middle Initial, Last Name, Suffix: ______________________

Date of Birth (MM/DD/YYYY): ______________ Social Security Number: ______________

Relationship to Retiree (See options below in instructions): ______________ Gender (M/F): ______

Plan Selection:

☐ Medical/Prescription ☐ Dental ☐ Vision

First Name, Middle Initial, Last Name, Suffix: ______________________

Date of Birth (MM/DD/YYYY): ______________ Social Security Number: ______________

Relationship to Retiree (See options below in instructions): ______________ Gender (M/F): ______

Plan Selection:

☐ Medical/Prescription ☐ Dental ☐ Vision

First Name, Middle Initial, Last Name, Suffix: ______________________

Date of Birth (MM/DD/YYYY): ______________ Social Security Number: ______________

Relationship to Retiree (See options below in instructions): ______________ Gender (M/F): ______

Plan Selection:

☐ Medical/Prescription ☐ Dental ☐ Vision

First Name, Middle Initial, Last Name, Suffix: ______________________

Date of Birth (MM/DD/YYYY): ______________ Social Security Number: ______________

Relationship to Retiree (See options below in instructions): ______________ Gender (M/F): ______

Plan Selection:

☐ Medical/Prescription ☐ Dental ☐ Vision

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SECTION C - ACKNOWLEDGMENT AND ACCEPTANCE (SIGNATURE REQUIRED)

By completing this form, I acknowledge and agree to the following.

I acknowledge receipt of the instructions for completing this form. I certify that the information on this form is true and complete to the best of my knowledge. I acknowledge that if I engage in, cause, or attempt to engage in any fraudulent activity related to my TRS-Care plan benefits, including giving false information on this form, I may be removed from the TRS-Care Program.

I acknowledge the information provided on this form may be disclosed to third parties that assist TRS in connection with the administration of the TRS-Care plan(s) in which I am enrolled. I agree to let the third parties engaged by TRS give information related to my TRS-Care plan benefits to TRS for the purpose of ensuring that the third party is providing the services as required.

I acknowledge and authorize TRS to take necessary action to ensure continuous coverage when I become eligible for Medicare and for TRS to obtain and share Medicare Beneficiary Identification information only with third parties directly regarding TRS-Care plan benefits while I am enrolled in the TRS-Care plan.

Information collected on 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 TRS-Care plan administration. I consent to calls or texts at these numbers and I understand the calls I receive could be automated. **I understand that I can cancel this consent to receiving calls and/or texts at these numbers at any time without affecting my eligibility for TRS-Care plan benefits**, enrollment, coverage, and/or my ability to get treatment. Upon request, TRS will provide me with the identity of the third parties who may communicate with me at these phone numbers, and I may contact those third parties directly regarding the use of my phone numbers. I also understand that data use charges and rates from my cellular carrier may apply.

I authorize the Teacher Retirement System of Texas (TRS) to withhold from my monthly annuity and remit to the third parties engaged by TRS to provide services under the TRS-Care plans I am enrolled in, 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(s), or I am not receiving a monthly annuity, I understand that TRS, or the third parties engaged by TRS to provide services under the TRS-Care plans, will bill me. I understand that it is my responsibility to send payment for any such bill on a timely basis. I understand if I fail to timely pay the full amount of a required contribution for each TRS-Care plan I am enrolled in, my coverage, and the coverage of any enrolled dependents, may be terminated. I understand if I lose my TRS-Care Dental and/or TRS-Care Vision coverage due to lack of payment of contribution, I may be subject to recoupment by TRS of outstanding contribution amounts, penalties, and be subject to reenrollment conditions prior to reenrollment in TRS-Care Dental and/or TRS-Care Vision plan(s).

I understand that only a TRS service retiree or a TRS disability retiree who meets the TRS-Care Program eligibility requirements may apply for TRS-Care Program coverage. I understand that any 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 are enrolled. I understand that as a service retiree under the TRS retirement plan, I am not eligible to enroll in the TRS-Care Program if I am eligible to enroll as an employee or retiree in a plan provided by the Employees Retirement System of Texas, The University of Texas System, or the Texas A&M University System. I agree to notify TRS immediately if such eligibility occurs in the future. I understand that if I am uncertain about whether I or my dependents are eligible for coverage under TRS-Care Program, I should contact TRS Health at (888) 237-6762 before signing and submitting this form. I certify that I and any dependents that I am enrolling are eligible to participate in TRS-Care Program.

I understand that if I am eligible as both a retiree and as a dependent of a retiree, I must only apply under one of those categories, and I cannot apply as both a retiree and a dependent of a retiree.

I understand that the TRS-Care plan year for coverage is from January 1 through December 31. I acknowledge that each year plan options may change, and it is my responsibility to review the plan options each plan year during open enrollment or special enrollment and request changes by timely submitting the appropriate form to TRS. Otherwise, TRS will automatically reenroll me and my eligible dependents in the elections of the prior year to ensure continuation of coverage. I agree to follow and comply with the TRS-Care enrollment and disenrollment process. I understand that once enrolled, I may only disenroll from dental and vision coverage during the next open enrollment period or during a special enrollment opportunity.

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

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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 was submitted to TRS on _____ (date) and/or is attached to this document.

Please be sure to sign and date this form below before it is returned to TRS.

Signature of retiree or authorized representative (Signature Required) **Date**

Printed name of retiree or authorized representative

Address _____ City _____ State _____ Zip _____

Phone Number _____

If signed by authorized representative, relationship to retiree _____