Dependent Termination of TRS-Care Insurance

TRS816-OL (10-21)

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

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

Please list the name(s) and date of birth for any dependent(s) you wish to terminate from your TRS-Care medical and prescription coverage.

Dependent Name	**Dependent DOB**

Dependent(s) termination will be effective the first of the month after this form is received by TRS, unless a future 1st of the month date is requested and approved by TRS. However, if the Centers for Medicare and Medicaid Services (CMS) advises TRS of a different termination date than requested for dependents eligible for Medicare, the CMS termination date will be the effective termination date.

My requested future dependent(s) termination date: _____

Please check the reason for termination.

☐ Cost ☐ Benefit Structure ☐ Return to Work ☐ Traditional Medicare Only

☐ 26th Birthday ☐ Divorce **(must provide copy of divorce decree)** ☐ Other: _____

- TRS-Care is not liable for any medical or prescription claims or expenses after the effective date of termination.
- Terminating dependent coverage after my initial eligibility enrollment period will not allow me to enroll my dependent later, except under Special Enrollment Event guidelines, or when I turn 65 years of age.
- The Dependent Termination of TRS-Care Insurance does not terminate TRS-Care Dental and/or TRS-Care Vision coverage for you and your covered dependents. Please contact TRS Health for more information on how to terminate TRS-Care Dental and/or TRS-Care Vision coverage.
- IMPORTANT: Please read. If after you submit this form to TRS-Care, you no longer want to terminate coverage for your dependent(s), you have 31-days from the date of termination to submit a signed Reinstatement of TRS-Care insurance form to have your dependent's coverage reinstated prospectively.

I understand the above and wish to terminate my dependent(s) TRS-Care coverage.

_____ _____
Policyholder Signature Date of Policyholder Signature