Termination of TRS-Care Insurance

TRS700B-OL (02-26)

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

Name _____ TRS Participant ID or Social Security Number _____

(First Name, Middle Initial, Last Name, Suffix)

I wish to terminate my current TRS-Care medical and prescription drug plan coverage. I understand the following:

- Termination will be effective on the first day of the month after the notarized *Termination of TRS-Care Insurance* (TRS700B) is received by TRS, unless a future date is requested and approved by TRS; accordingly, my termination may be effective. However, if the Centers for Medicare and Medicaid Services (CMS) advises TRS of a different termination date than , the CMS termination date will be my effective termination date.
- TRS-Care is not liable for any medical or prescription claims or expenses after my effective date of termination.
- This termination request is effective for myself and all of my covered dependents.
- If I terminate coverage after my initial eligibility/enrollment period. I will not be allowed to enroll later, unless there is a Qualifying Life Event, or when I turn 65 years of age.
- The TRS700B does not terminate TRS-Care Dental or TRS-Care Vision coverage for me or my covered dependents. (Please contact TRS Health for more information on how to terminate TRS-Care Dental or TRS-Care Vision coverage during the annual enrollment period).
- **Limited time reinstatement opportunity**: If after submitting this form to TRS Health, I decide not to terminate my coverage, I may contact TRS Health to request a reinstatement form. I must complete and submit the form to TRS Health within thirty-one (31) days of the termination effective date. If approved, my coverage will be reinstated on the first day of the month after TRS Health receives my request. TRS-Care will not provide coverage between the termination effective date and the reinstatement effective date.

Please check the reason for termination: (Answering this question is voluntary and will not affect your request for termination).

☐ Cost ☐ Benefit Structure ☐ Return to Work ☐ Traditional Medicare only ☐ Other _____

I understand the above and wish to terminate my participation in and coverage by TRS-Care.

I understand that my signature (or 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 was submitted to TRS on _____(date) and/or is attached to this document.**

_____ _____

Retiree Signature or authorized representative Witnessed by a Notary Public Date Retiree Signed

Sworn and subscribed before me on this _____ day of _____ , _____

(SEAL) _____

Signature of Notary Public

_____

Date Commission Expires

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DO NOT COMPLETE OR SEND THIS FORM TO TRS IF YOU WANT YOUR TRS-CARE COVERAGE TO REMAIN AS IT IS.

Contact TRS-Health if you have any questions about your TRS-Care coverage.

When you reach age 65, you will have an opportunity to re-enroll into TRS-Care. You may also have the opportunity to re-enroll in TRS-Care if TRS has an additional enrollment opportunity or with a Qualifying Life Event.

Sign this form in front of a Notary Public and return it by mail to TRS Health at the address above. Coverage will terminate on the first day of the month following TRS Health receipt.

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