Limited Time Enrollment Opportunity Application

TRS700LT-OL (08-26)

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

This application should be completed by the TRS retiree, surviving spouse, or surviving dependent child enrolling in TRS-Care Medical and prescription drug coverage under the Limited Time Enrollment Opportunity

Read all the information provided in the enclosed enrollment packet before completing this application. 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.

A section on your enrollment form asks for Race and Ethnicity information for each participant you are enrolling. It 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 the Centers for Medicare and Medicaid Services (CMS), 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.

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

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

- **SECTION A** – Retiree, Surviving Spouse or Surviving Dependent 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, SURVIVING SPOUSE, OR SURVIVING DEPENDENT CHILD 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

Who do you want to enroll?

☐ Retiree or Surviving Spouse	☐ Retiree and Spouse
☐ Retiree or Surviving Spouse and Child(ren)	☐ Retiree, Spouse and Child(ren)
☐ Surviving Dependent Child	☐ Surviving Dependent Child and Siblings

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Retiree, Surviving Spouse or Surviving Dependent 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. TRS must be able to verify your Medicare Part B enrollment prior to enrollment.

What is your Medicare Number? _____

What part(s) of Medicare do you have?

☐ Medicare Part A - Effective Date _____

☐ Medicare Part B - Effective Date _____

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

Answering this ethnicity question is voluntary and will not impact your coverage if you choose not to answer.

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

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

Answering this race question is voluntary and will not impact your coverage if you choose not to answer.

☐ American Indian or Alaska Native	☐ Asian Indian	☐ Black or African American
☐ Chinese	☐ Flipino	☐ Guamanian or Chamorro
☐ Japanese	☐ Korean	☐ Native Hawiian
☐ 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. A surviving spouse may not enroll a new spouse.

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

Date of Birth _____ Social Security Number _____

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 _____

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

Answering this ethnicity question is voluntary and will not impact your spouse's coverage if you choose not to answer.

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

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

Answering this race question is voluntary and will not impact your spouse's coverage if you choose not to answer.

☐ American Indian or Alaska Native	☐ Asian Indian	☐ Black or African American
☐ Chinese	☐ Flipino	☐ Guamanian or Chamorro
☐ Japanese	☐ Korean	☐ Native Hawiian
☐ 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 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 _____

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

Answering this ethnicity question is voluntary and will not impact your child's coverage if you choose not to answer.

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

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

Answering this race question is voluntary and will not impact your child's coverage if you choose not to answer.

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

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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.

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.

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

RETIREE, SURVIVING SPOUSE, OR SURVIVING DEPENDENT CHILD INFORMATION

The following information must be completed and signed by the retiree, surviving spouse or dependent child.

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.
A surviving spouse cannot enroll a new spouse.

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

Printed name of Authorized Representative, if applicable _____

If you are the authorized **Representativ**e, 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 that 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 _____