



Termination of TRS-Care Dental and/or TRS-Care Vision Coverage

TRSDVOE-TERM (10/25)

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 am requesting termination of TRS-Care Dental and/or TRS-Care Vision coverage as indicated below. I understand the following:

- **Termination will be effective January 1.** If I elect to terminate coverage for TRS-Care Dental and/or TRS-Care Vision **for myself, coverage for dependent(s)** will also terminate. This means termination of coverage by the Retiree or Surviving Spouse applies to all enrolled dependents.
- The *TRSDVOE-TERM* form **does NOT terminate TRS-Care Medical and Prescription Drug** coverage. (Contact TRS Health for more information on how to terminate TRS-Care Medical and Prescription Drug coverage.)
- The TRS-Care Dental and TRS-Care Vision plan year runs from January 1 through December 31. If I choose to terminate coverage, I understand that I **can only re-enroll during the next open enrollment unless there is a qualifying life event.**
- TRS will mail confirmation of my request to terminate TRS-Care Dental and/or TRS-Care Vision coverage within 5-7 business days of processing this request.

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 Other: _____

Complete the following information and sign prior to returning to TRS:

Name:

Terminate Coverage:

_____	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision
_____	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision
_____	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision
_____	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision
_____	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision

Signature

Date

TRS Health
Teacher Retirement System of Texas
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