Instructions for Participants without Medicare to Complete the Application to Re-enroll in TRS-Care

During the 2018 TRS-Care Grace Period through Feb. 28, 2018

Please complete a single 700GP application to re-enroll all participants without Medicare in TRS-Care. The application must be received by fax or post-marked no later than February 28, 2018.

The retiree is only required to complete a single TRS700GP application for themselves and their dependents if all covered under the plan do not have Medicare.

If the retiree does not have Medicare and other dependents do have Medicare, the retiree should complete the TRS700GP for themselves and any dependents without Medicare and a separate TRS700GPM and TRS-Care Medicare Rx enrollment form for each dependent who has Medicare.*

Please fax all pages back to TRS at (512) 542-6575 or mail all pages to TRS at the address on the application. The application must be received by fax or post-marked no later than February 28, 2018. Your coverage will be effective the first day of the month following the time we receive your application.

If you have questions about how to complete the application, please contact TRS Health & Insurance Benefits at 1-888-237-6762.

Important Information

If you choose to re-enroll in TRS-Care, you will be reinstated in the coverage you would have had on Jan. 1, 2018, had you not terminated TRS-Care. This is not an opportunity to add new dependents. You can only reinstate participants that were previously covered under TRS-Care and were terminated from TRS-Care coverage between July 1, 2017 and January 1, 2018.

*If anyone covered by the plan has Medicare, you will need to complete the 700GPM application and TRS-Care Medicare Rx enrollment form for each enrollee with Medicare. You can find that application on the TRS website at www.trs.texas.gov/Pages/healthcare_trscare_grace_period.aspx.

TRS 700GP
Rev. 01-18

TEACHER RETIREMENT SYSTEM OF TEXAS
1000 Red River Street, Austin, Texas 78701-2698
Telephone 1 (888) 237-6762
www.trs.texas.gov

TRS-CARE STANDARD PLAN GRACE PERIOD RE-ENROLLMENT APPLICATION

EFFECTIVE DATE
First of the month following receipt by TRS of your application to re-enroll

Name: _____ Primary Phone #: _____

Address: _____ E-mail Address: _____

SSN: _____ Date of Birth: _____

Please provide your physical residential address if the mailing address above is a PO Box.

_____
Street Address City State Zip Code

SECTION A **Please check the box below if you want to re-enroll in the TRS-Care Standard Medical Plan.**

☐ **TRS-CARE STANDARD MEDICAL PLAN**

SECTION B **Please complete only if you are re-enrolling a spouse or eligible children. Attach an additional page to add more than one child.**

Spouse's Name _____ Date of Birth _____
First Name Last Name

Social Security #: _____ Gender: ☐ Male ☐ Female

If your **spouse** is eligible for Medicare, they will complete and sign the 700GPM available online.

Child's Name _____ Date of Birth _____
First Name Last Name

Social Security #: _____ Gender: ☐ Male ☐ Female

If your **dependent child** is eligible for Medicare, please complete and sign the 700GPM available online. Please contact TRS Health & Insurance Benefits for the appropriate forms if you have a child that has a mental disability or is physically incapacitated that you want to add to TRS-Care.

SECTION C	Acknowledgement and Acceptance

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.

I acknowledge that my confidential information may be disclosed to third parties that assist TRS in connection with the administration of the health plan in which I am enrolled.

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 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 the identity of the third parties that may be communicating 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 (TRS) to withhold from my monthly annuity and remit to TRS-Care any amount necessary to cover my share of the cost of the selected 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 coverage and termination of coverage for any of my eligible dependents.

Please note that future plan options may change.

Signature _____ Date _____

Return complete form to:
TRS Health & Insurance Benefits
Teacher Retirement System of Texas
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Telephone 1 (888) 237-6762
Fax (512) 542-6575
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