

TRS-ActiveCare COVERAGE DECLINATION FORM

Employee Number		YOUR PERSONAL INFORMATION		Campus	Occupation	
<input type="checkbox"/> Male	<input type="checkbox"/> Married	Last Name		First Name		Middle Initial
<input type="checkbox"/> Female	<input type="checkbox"/> Single					
Birth Date (MM/DD/YYYY)		Social Security Number		Work Phone Number	Home Phone Number	
Mailing Address				City	State	Zip
Home E-Mail Address						

DECLINING HEALTH COVERAGE

This is to certify that the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage as indicated below. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage as well as a preexisting condition exclusion period (not applicable to HMO coverage). Effective September 1, 2011, a preexisting condition waiting period is not applicable for any individual under the age of 19.

Maintain a copy of this form in your personal files. You will need to present it in the event you or any of your dependents listed below experience a mid-year qualifying event and want to enroll in TRS-ActiveCare coverage in the future.

YOU MUST INDICATE THE REASON FOR THE DECLINATION FOR EACH PERSON NAMED BELOW OR THIS FORM WILL NOT BE VALID

Name <input type="checkbox"/> Employee	Reason for declining: <input type="checkbox"/> Has Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, Explain:
Name <input type="checkbox"/> Spouse	Reason for declining: <input type="checkbox"/> Has Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, Explain:
Name <input type="checkbox"/> Dependent Child	Reason for declining: <input type="checkbox"/> Has Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, Explain:
Name <input type="checkbox"/> Dependent Child	Reason for declining: <input type="checkbox"/> Has Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, Explain:
Name <input type="checkbox"/> Dependent Child	Reason for declining: <input type="checkbox"/> Has Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, Explain:
Name <input type="checkbox"/> Dependent Child	Reason for declining: <input type="checkbox"/> Has Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, Explain:
Name <input type="checkbox"/> Dependent Child	Reason for declining: <input type="checkbox"/> Has Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, Explain:

I understand that by signing this form I am also accepting responsibility for sending a copy of this form to TRS-ActiveCare at the address below.

Signature _____ Date _____

It is the employee's responsibility to mail this form to: **Blue Cross and Blue Shield of Texas**
P.O. Box 660400
Dallas, TX 75266-0400