What should be considered after a life-changing event?

For the purposes of this document, we will confine our examples to the following events:

- Marriage
- Divorce
- Birth or adoption of a child
- Loss or Gain of other health insurance
- Death of a family member

Things to *consider* if one of these qualifying events occur:

- Changing your legal name (must have a new social security card)
- Federal tax exemptions (W-4)
- Direct deposit bank account (prior to closing your current account)
- Change in mailing address
- Change in your beneficiary for life insurance & TRS
- Change in your health insurance or supplemental benefits

If a qualifying event occurs, you must contact the Benefits Office IN WRITING within 31 days from the date the 'event' occurred. Do not miss your opportunity! Due to Section 125, we will not be able to make any changes after that 31 day window ends.

You must complete the appropriate enrollment forms (Enrollment Application & Change form for changes to your medical coverage). We will also need written documentation of the family status change.

Examples:

1. Loss of insurance coverage – we will need a letter from the previous health insurance carrier indicating the date the coverage ended.
2. Spouse gains employment with benefits – we will need a letter on company letterhead indicating hire date and effective date of insurance or proof of coverage with dates.
3. Divorce – we will need a copy of the signed decree.
4. Marriage – we will need a copy of the marriage certificate.

BIRTH or ADOPTION

If you have a new addition to your family, you have 31 days to get the information in writing to the Benefits Office. TRS Active Care provides coverage for a newborn child of a covered employee for the first 31 days after the date of birth. Do not miss your opportunity to add your child to your health insurance as TRS doesn't allow any additions after the 31 day window ends. Do not wait for the newborn's social security number as this can be added when it is received.

FORMS

The following forms are attached for your convenience.

- W-4 – see attached
- Designation of Beneficiary (TRS) – see attached
- Enrollment Application & Change form (for medical) – see attached

PERSONNEL Changes/Name/Address/Phone/Direct Deposit – must be done through Talent Ed

For costs of benefits, please go to the benefits website http://benefits.ffga.com/coppellisd

Form W-4 (2017)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A
B	Enter "1" if: • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child.	G
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ▶	H

For accuracy, complete all worksheets that apply.

- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Separate here and give Form W-4 to your employer. Keep the top part for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2017

1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐	
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	5	
6 Additional amount, if any, you want withheld from each paycheck	6 $	
7 I claim exemption from withholding for 2017, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7	

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ▶ **Date** ▶

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over $313,800 and you're married filing jointly or you're a qualifying widow(er); $287,650 if you're head of household; $261,500 if you're single, not head of household and not a qualifying widow(er); or $156,900 if you're married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,700 if married filing jointly or qualifying widow(er); $9,350 if head of household; $6,350 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2017 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2017 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2017 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note: Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2017. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2017. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $7,000	0	$0 - $8,000	0
7,001 - 14,000	1	8,001 - 16,000	1
14,001 - 22,000	2	16,001 - 26,000	2
22,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 70,000	5
44,001 - 55,000	6	70,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 95,000	10	140,001 and over	10
95,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

TEACHER RETIREMENT SYSTEM OF TEXAS
1000 Red River Street, Austin, Texas 78701-2698
Telephone (512) 542-6400 or 1-800-223-8778
www.trs.state.tx.us

TRS 15
Rev. 01-12

DESIGNATION OF BENEFICIARY

Name _____ Social Security No. _____
(As it appears on TRS records)

Complete this form TRS 15 to designate a beneficiary or beneficiaries for active member death benefits or retiree survivor benefits. Please read the Instructions and Information for Designating a Beneficiary on the reverse side for important information about completing this form and how TRS will use this form.

PRIMARY BENEFICIARY OR JOINT PRIMARY BENEFICIARIES

I designate the following person(s) as my primary beneficiary(ies) to receive the benefits described above that may be due from TRS upon my death (surviving designated joint primary beneficiaries will receive equal portions, share and share alike):

Name	Social Security No.	Relationship	Date of Birth	Address

ALTERNATE BENEFICIARY OR JOINT ALTERNATE BENEFICIARIES

In the event the primary beneficiary(ies) predeceases me, waives the benefits, or is ineligible to receive the benefits, I designate the following person(s) as my alternate beneficiary(ies), to receive the benefits described above that may be due from TRS upon my death (surviving designated joint alternate beneficiaries will receive equal portions, share and share alike):

Name	Social Security No.	Relationship	Date of Birth	Address

A blank designation of beneficiary on a TRS form that is signed by you revokes any previous designation for the applicable benefits and leaves **no designation of beneficiary.** When no beneficiary is designated, applicable law determines who will receive benefits after your death.

_____ _____
Signature of Member or Retiree Date

STATE OF _____ COUNTY OF _____

On _____ (date), _____ (printed name of person whose signature appears above) acknowledged this document before me a notary public.

(SEAL)

_____
Signature of Notary Public

This form TRS 15 cannot be used to designate a beneficiary(ies) for monthly retirement benefits under an optional retirement payment plan (Option 1, 2, 3, 4, or 5). If you wish to change your beneficiary under an optional retirement payment plan, request a Change of Beneficiary for Continuing Optional Retirement Annuity form from TRS.

INSTRUCTIONS AND INFORMATION FOR DESIGNATING A BENEFICIARY

- YOU MUST USE THE CORRECT TRS FORM. THE TRS FORM MUST INCLUDE AN ORIGINAL SIGNATURE. TRS RECOMMENDS THAT YOU SIGN IN INK AND USE A COLOR OTHER THAN BLACK. PLEASE TYPE OR PRINT YOUR DESIGNATION LEGIBLY. REFER TO THE TRS BENEFITS HANDBOOK FOR INFORMATION ABOUT BENEFITS PAYABLE UPON THE DEATH OF AN ACTIVE MEMBER OR RETIREE.

- TRS must receive a TRS beneficiary form before your death for the beneficiary designation to be effective. Your employer is not authorized to receive the form instead of TRS; do not leave this form with your employer.

- Please provide enough information for TRS to identify you, and to identify and locate your beneficiary after your death (ie: your full name and social security number).

- Initial any corrections, mark-outs, or white-outs made on the form to avoid possible disputes. TRS will not accept stipulations or instructions you write on the form for the payment or division of benefits; TRS will pay benefits according to applicable law. No attachments may be made to the form.

- If you designate more than one beneficiary, the surviving beneficiaries will share equally in any death or survivor benefits. This means that if one designated beneficiary dies before you die, then any remaining surviving beneficiaries will receive equal shares of the benefits. Do not stipulate unequal portions to joint beneficiaries.

- If you do not designate a primary beneficiary but you designate an alternate beneficiary, the alternate beneficiary will receive any benefits payable.

- A blank designation of beneficiary on a TRS form that is signed by you revokes any previous designation for the applicable benefits and leaves **no designation of beneficiary**. When no beneficiary is designated, applicable law determines who will receive benefits after your death. When TRS receives a new beneficiary designation form, it revokes any previous designation for the benefits affected by the form. To add or remove a designated beneficiary, you must complete the new applicable form in its entirety and send it to TRS. You may want to complete a new form in its entirety after events such as marriage, divorce, death of a named beneficiary, birth of a child, or if your beneficiary becomes eligible for Medicaid benefits or a needs-based assistance program.

- If you designate a minor, any benefits will be paid to the surviving parent or the court-appointed guardian of the minor based on the laws in the minor's state of residence.

- If you wish to have any benefits paid to your estate, designate "my estate" as beneficiary. Your estate can be named as either primary or alternate beneficiary. Your estate must be probated in some manner for TRS to pay benefits to your estate. Naming your estate may delay payment of benefits while the required documents are obtained from the court.

- TRS will accept a beneficiary designation form that is not notarized; however, TRS strongly recommends that you have the form notarized to avoid any disagreement about your signature after your death.

- A divorce will revoke your former spouse as beneficiary for some TRS benefits payable after your death *if* you designated that person as your beneficiary before the date of your divorce *and if* TRS receives a certified copy of your divorce decree before paying benefits. If you wish to designate your former spouse as beneficiary, complete a new beneficiary form **after** the date of the divorce and send it to TRS. Receipt by TRS of a divorce decree does **not** affect the beneficiary for an Option 1, 2, 3, 4, or 5 retirement payment plan, a remaining partial lump sum option (PLSO) balance, or a remaining deferred retirement option plan (DROP) balance.

- If you die before you receive all of your DROP or PLSO payments, any remaining DROP or PLSO balance will be distributed in the following order: (1) to the beneficiary designated on the *"Designation of Beneficiary for Deferred Retirement Option Plan (DROP) Benefits"* (form TRS 11D) or the *"Designation of Beneficiary for Partial Lump-Sum Payment(s)"* (form TRS 12L), as applicable; (2) to the beneficiary designated to receive your retirement benefits; then, (3) to the beneficiary eligible to receive death and survivor benefits.

- If you have questions or circumstances not covered by these instructions, please contact TRS.

TRS ActiveCare

Enrollment Application and Change Form

WellSystems®

ELIGIBILITY:	Are you an active employee and making monthly contributions to TRS? ☐ Yes ☐ No If no, are you regularly scheduled to work 10 or more hours per week? ☐ Yes ☐ No	(If no to both, you are not eligible for TRS ActiveCare coverage)

SECTION 1: ENROLLMENT/CHANGE TRANSACTION TYPE

☐ Annual Enrollment ☐ New Employee ☐ Add Dependent ☐ Special Enrollment

☐ For New Employee (check one): ☐ Effective on Actively at Work ☐ Effective 1st day of month following

Special Enrollment Event Date: __/__/____ ☐ Marriage ☐ Court Order ☐ Birth/Adoption ☐ Loss of Coverage ☐ Other:

Change Only:
☐ Name
☐ Address
☐ Plan/Coverage

Decline Coverage:
☐ Yes (Complete Section 6)
☐ N/A

Effective Date of Change/Cancel
____/____/____

Cancel Employee
☐ Death
☐ Loss of Eligibility
☐ Retirement/Terminated
☐ Non-Payment
☐ Other: _____

Cancel Dependent
☐ Divorce
☐ Death
☐ Loss of Eligibility
☐ Dropped Coverage
☐ Other: _____

For District Use Only
TRS District #:
Actively at Work Date:
Effective/Change Date:
Employer Approval:

Were you covered by another district? ☐ Yes ☐ No
If so, which: _____

SECTION 2: EMPLOYEE INFORMATION

Last Name:	First Name:	MI:	Social Security #:
Mailing Address:	City:	State:	Zip:
Home Phone Number:	Cell Phone Number:	Email:	
Date of Birth:	Sex: ☐ M ☐ F	Language: ☐ English ☐ Spanish	Ethnicity:

Do you have a disability affecting your ability to communicate or read? ☐ Yes (Please complete Section 8) ☐ No

Is the Employee Covered By Other Insurance? ☐ Yes Carrier/Plan: ☐ No

Is the Employee Covered by Medicare? ☐ Yes ☐ Part A ☐ Part B ☐ Part C ☐ Part D Effective: ☐ No

Reason for Medicare Coverage: ☐ Entitlement Age ☐ Disability ☐ End Stage Renal Disease (ESRD)

SECTION 3: COVERAGE SELECTION (Please select a Plan of Coverage – Plan or HMO - and Coverage Type)

Plan Selection: ☐ ActiveCare 1-HD ☐ ActiveCare Select ☐ ActiveCare 2

HMO Selection: ☐ FirstCare Health Plans ☐ Scott & White Health Plan ☐ Allegian Health Plans (formerly Valley Baptist Health Plans)

Coverage Type Selected: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

SECTION 4: DEPENDENT INFORMATION (Use additional form for additional dependents)

SPOUSE Last Name: | First Name: | MI:

Street Address: ☐ Same as Employee

City: | State: | Zip: | Phone Number:

Sex: ☐ M ☐ F | Date of Birth: | Social Security #:

Other Insurance: ☐ Yes, Carrier/Plan ☐ No ☐ Medicare: ☐ Part A ☐ Part B ☐ Part C ☐ Part D

CHILD Last Name: | First Name: | MI:

☐ Natural/Adopted ☐ Stepchild ☐ Foster Child ☐ Grandchild ☐ Legal Guardian ☐ Disabled ☐ Other

Street Address: ☐ Same as Employee

City: | State: | Zip Code: | Phone Number:

Date of Birth: | Social Security #: | Sex: ☐ M ☐ F

Other Insurance: ☐ Yes, Carrier/Plan ☐ No ☐ Medicare: ☐ Part A ☐ Part B ☐ Part C ☐ Part D

CHILD Last Name: | First Name: | MI:

☐ Natural/Adopted ☐ Stepchild ☐ Foster Child ☐ Grandchild ☐ Legal Guardian ☐ Disabled ☐ Other

Street Address: ☐ Same as Employee

City: | State: | Zip Code: | Phone Number:

Date of Birth: | Social Security #: | Sex: ☐ M ☐ F

Other Insurance: ☐ Yes, Carrier/Plan ☐ No ☐ Medicare: ☐ Part A ☐ Part B ☐ Part C ☐ Part D

PLEASE CONTINUE ON NEXT PAGE

CHILD Last Name:	First Name:	MI:
☐Natural/Adopted ☐Stepchild ☐Foster Child ☐Grandchild ☐Legal Guardian ☐Disabled ☐ Other		
Street Address:		☐Same as Employee
City:	State:	Zip Code:	Phone Number:
Date of Birth:	Social Security #:	Sex: ☐M ☐F
Other Insurance: ☐Yes. Carrier/Plan	☐No ☐Medicare: ☐Part A ☐Part B ☐Part C ☐Part D	
CHILD Last Name:	First Name:	MI:
☐Natural/Adopted ☐Stepchild ☐Foster Child ☐Grandchild ☐Legal Guardian ☐Disabled ☐ Other		
Street Address:		☐Same as Employee
City:	State:	Zip Code:	Phone Number:
Date of Birth:	Social Security #:	Sex: ☐M ☐F:
Other Insurance: ☐Yes. Carrier/Plan	☐No ☐Medicare: ☐Part A ☐Part B ☐Part C ☐Part D	

SECTION 5: DISABLED DEPENDENTS OVER AGE 26 ☐Request for Continuation of Coverage for Handicapped Child form and Attending Physician's Statement

Please note that a Request for Continuation of Coverage for Handicapped Child form and Attending Physician's Statement are required for coverage of a disabled child over age 26. See your Benefits Administrator for the forms, which must be completed in full and submitted to your Benefits Administrator.

SECTION 6: DECLINATION OF 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 available to me and my dependents and have voluntarily elected to decline the coverage as elected below.

Name:	SSN:	☐Employee	Reason:	☐Other Coverage	☐Other:
Name:		☐Spouse	Reason:	☐Other Coverage	☐Other:
Name:		☐Child	Reason:	☐Other Coverage	☐Other:
Name:		☐Child	Reason:	☐Other Coverage	☐Other:
Name:		☐Child	Reason:	☐Other Coverage	☐Other:
Name:		☐Child	Reason:	☐Other Coverage	☐Other:

SECTION 7: COVERAGE CONDITIONS

- I am employed by the Employer named in this Enrollment Application and Change Form. I am eligible to participate in the coverage(s) offered by the TRS-ActiveCare program which is administered by Aetna, with HMO benefits provided by SHA, L.L.C. dba FirstCare Health Plan, Scott and White Health Plan, and Allegian Insurance Company dba Allegian Health Plans. On behalf of myself and any dependents listed on their Enrollment Application and Change Form, I apply for those coverage(s) for which I am eligible.
  - If I am enrolling a grandchild in Section 4, I certify that my household is the grandchild's primary residence and the grandchild is my dependent for federal income tax purposes for the reporting year in which coverage of the grandchild is in effect.
  - If I am enrolling a child as an "other Child" in Section 4, I certify that my household is the child's primary residence, that I provide at least 50% of the child support, that neither of the children's natural parents reside in my household, and that I have the legal right to make decisions regarding the child's medical care.
- Only those coverage(s) and amount for which I am eligible will be available to me. I understand that if this Enrollment Application and Change Form is accepted, the coverage(s) will become effective in accordance with the provisions or the TRS-ActiveCare program.
- I understand that by enrolling for coverage with Employer named in the Enrollment Application and Change Form that any TRS-ActiveCare coverage I previously elected under another TRS-ActiveCare participating district/entity will be terminated under TRS Rules.
- I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s). I agree that my Employer acts as my agent. All notices given to my Employer are binding upon me. I also agree that my participation in the coverage(s) is subject to any future amendments.
- I understand that by declining TRS-ActiveCare coverage now or by terminating TRS-ActiveCare coverage during the plan year, I am not eligible to re-enroll in TRS-ActiveCare until the next plan year, unless I experience a special enrollment event.
- I state that the information given on the Enrollment Application and Change Form is true and correct. I understand and agree that any incorrect statements material to the risk and knowingly made by me will invalidate my coverage(s).

Applicant Signature: _____ Date: _____

SECTION 8: SPECIAL NOTES REGARDING MY ENROLLMENT (Please indicate any special information regarding my enrollment for Aetna, Caremark or my selected HMO)