MEDICARE ELIGIBLE HEALTH PLAN (MEHP)

Medical & Prescription Drug Enrollment Form for the

TEACHERS' RETIREMENT SYSTEM (TRS)

479 Versailles Road, Frankfort, KY 40601
Phone: 502-848-8500 or 800-618-1687 Fax: 502-573-0199

TRS USE ONLY

_____
Effective Date

Reason for Application			
☐ Turning 65	☐ Qualifying Event	☐ Open Enrollment	☐ New Retiree

ENROLLMENT TYPE: (for TRS MEHP only) Select one

☐ Retiree Only ☐ Retiree & Spouse ☐ Spouse Only

RETIREE INFORMATION

Retiree Name	**Retiree** Social Security or TRS Member ID #	
Retiree Date of Birth	Gender: ☐ Male ☐ Female	Married: ☐ YES ☐ NO

SPOUSE INFORMATION

Spouse Name	**Spouse** Social Security Number	Date of Birth
Retiree Social Security or TRS Member ID #	Gender: ☐ Male ☐ Female	Married: ☐ YES ☐ NO

WAIVER OF COVERAGE

☐ I, the **retiree**, wish to **waive** coverage. **Signature:** _____

☐ I, the **spouse**, wish to **waive** coverage. **Signature:** _____

Your MEHP enrollment is contingent on your Medicare enrollment. Also, if you are enrolled in another Medicare Advantage plan, another Medicare Part D prescription drug plan or your Medicare Part B coverage terminates, your TRS MEHP will be terminated. Upon waiver or termination of the MEHP, if you are the spouse of a TRS retiree, you will not be eligible for future re-enrollment unless you have a valid TRS qualifying event. For TRS retirees, changes after the effective date of your insurance may only be made during Open Enrollment or within 30 days of a qualifying event. Obtaining Medicare Part B is considered a qualifying event for TRS retirees only; but you will only have 30 days from the event to enroll.

Use your Medicare card to complete this page and return with a copy of the card to TRS. If you have applied but not yet received your Medicare card, you must contact your local Social Security office to request your Medicare number and effective dates for Medicare Parts A and B.

Complete if RETIREE is enrolling in the TRS MEHP	
Retiree Name	Social Security Number
Medicare Number **(Ex. 1EG4-TE5-MK72)** ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___	Hospital Part A Effective Date Medical Part B Effective Date **(REQUIRED)**
Do you have End Stage Renal Disease (ESRD)? ☐ YES ☐ NO	

Complete if SPOUSE is enrolling in the TRS MEHP	
Spouse Name	Social Security Number
Medicare Number **(Ex. 1EG4-TE5-MK72)** ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___	Hospital Part A Effective Date **(REQUIRED)** Medical Part B Effective Date **(REQUIRED)**
Do you have End Stage Renal Disease (ESRD)? ☐ YES ☐ NO	

DEMOGRAPHIC INFORMATION		
Mailing Address		
City	State	ZIP
PERMANENT Street Address (P.O. Box Not Allowed)		
City	State	ZIP
Email Address	Home Phone	Cell Phone

By signing below, I confirm I have read and understand all the enclosed materials pertaining to the TRS MEHP coverage. I also understand that if Medicare indicates I have gone 63 or more days in a row without creditable prescription drug coverage that I may receive a form asking about prior drug coverage. If I don't complete the form, I may be required to pay a monthly premium penalty to TRS.

RETIREE'S SIGNATURE _____ **DATE** _____, 20 _____

SPOUSE'S SIGNATURE
(If enrolling in coverage) _____ **DATE** _____, 20 _____