

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

Complete your enrollment through the Pathway member account access website at <https://mss.trs.ky.gov/>

Reason for Application				TRS USE ONLY _____ Effective Date
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Turning 65	Qualifying Event	Open Enrollment	New Retiree	

ENROLLMENT TYPE: (for TRS MEHP only) Select one		
<input type="checkbox"/> Retiree Only	<input type="checkbox"/> Retiree & Spouse	<input type="checkbox"/> Spouse Only

RETIREE INFORMATION		
Complete only if RETIREE is enrolling in/waiving the TRS MEHP		
Retiree Name	Retiree Social Security or TRS Member ID #	
Retiree Date of Birth	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Married: <input type="checkbox"/> YES <input type="checkbox"/> NO

SPOUSE INFORMATION		
Complete only if SPOUSE is enrolling in/waiving the TRS MEHP		
Spouse Name	Spouse Social Security Number	Date of Birth
Retiree Social Security or TRS Member ID #	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Married: <input type="checkbox"/> YES <input type="checkbox"/> NO

WAIVER OF COVERAGE	
<input type="checkbox"/> I, the retiree , wish to waive coverage.	Signature: _____
<input type="checkbox"/> 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.



IMPORTANT

Complete your enrollment through the Pathway member account access website at <https://mss.trs.ky.gov/> by using your Medicare card to complete this page and upload a copy of the card. If you have applied but not yet received your Medicare card, contact Social Security or sign up for your *my* Social Security account at www.ssa.gov to obtain your Medicare number and effective dates.

Complete if RETIREE is enrolling in the TRS MEHP	
Retiree Name	Social Security Number
Medicare Number – located on your Medicare card (Ex. 1EG4-TE5-MK72) _____ - _____ - _____	Hospital Part A Effective Date
	Medical Part B Effective Date (REQUIRED)
Do you have End Stage Renal Disease (ESRD)? <input type="checkbox"/> YES <input type="checkbox"/> NO	

Complete if SPOUSE is enrolling in the TRS MEHP	
Spouse Name	Social Security Number
Medicare Number – located on your Medicare card (Ex. 1EG4-TE5-MK72) _____ - _____ - _____	Hospital Part A Effective Date (REQUIRED)
	Medical Part B Effective Date (REQUIRED)
Do you have End Stage Renal Disease (ESRD)? <input type="checkbox"/> YES <input type="checkbox"/> NO	

DEMOGRAPHIC INFORMATION		
Mailing Address		
City	State	ZIP
PERMANENT Street Address (REQUIRED) if Mailing Address is a P.O. Box, P.O. Box Not Allowed		
City	State	ZIP
Email Address	Primary Phone	Alternative Phone

By signing below, I confirm I have read and understand all the available 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** _____
(REQUIRED)

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