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

Complete enrollment through Pathway Member Self Service website at https://mss.trs.ky.gov/ OR by completing this form and returning to TRS

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

TRS USE ONLY

_____
Effective Date

ENROLLMENT TYPE: (for TRS MEHP only) Select one

☐ Retiree Only ☐ Retiree & Spouse ☐ Spouse Only

RETIREE INFORMATION

Complete this section if application is for the RETIREE

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

SPOUSE INFORMATION

Complete this section if application is for the SPOUSE

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

Complete this section only if you DO NOT want to enroll in TRS MEHP 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.

IMPORTANT

Complete enrollment through Pathway Member Self Service website at https://mss.trs.ky.gov/ OR by completing this form. Use your Medicare card to complete this page. Include a copy of the card with this form, or upload a copy of the card to the online MSS application. 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 (As shown on your Medicare Card)	Social Security Number
Medicare Number – (REQUIRED) *located on your Medicare card* ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___	Hospital Part A Effective Date Medical Part B Effective Date **(REQUIRED)**
(REQUIRED) Do you have End Stage Renal Disease (ESRD)? ☐ YES ☐ NO	

Complete if SPOUSE is enrolling in the TRS MEHP	
Spouse Name (As shown on your Medicare Card)	Social Security Number
Medicare Number – (REQUIRED) *located on your Medicare card* ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___	Hospital Part A Effective Date **(REQUIRED)** Medical Part B Effective Date **(REQUIRED)**
(REQUIRED) Do you have End Stage Renal Disease (ESRD)? ☐ YES ☐ 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** _____