MEDICARE ELIGIBLE HEALTH PLAN (MEHP)

Medical & Prescription Drug Enrollment Form

TEACHERS' RETIREMENT SYSTEM (TRS)

479 Versailles Road, Frankfort, KY 40601

Phone: 502-848-8500 or 800-618-1687; Fax: 502-848-8550

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

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

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	**Spouse** 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:** _____ **Date:**_____

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

* I N - M E - 0 7 F *

MEHP enrollment is contingent on Medicare enrollment. If you enroll in another Medicare Advantage or Medicare Part D plan, or your Medicare Part B coverage terminates, your TRS MEHP will terminate. 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 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.

TRS Health Care Eligibility Due to Employment:

Retirees and or spouses eligible for employer health insurance coverage are NOT eligible for TRS coverage. If eligible through employer, TRS coverage MUST be dropped. Retirees and or spouses can enroll in TRS coverage within 30 calendar days of losing employer coverage.

IMPORTANT

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 received your Medicare card, contact Social Security or sign up for your *my* Social Security account at www.ssa.gov to obtain your Medicare information.

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) At the time TRS MEHP coverage is needed, will you be working AND eligible for employer health insurance? ☐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) At the time TRS MEHP coverage is needed, will you be working AND eligible for employer health insurance? ☐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 certify that I am not currently eligible for active employment insurance. I understand that if Medicare indicates I have gone 63 or more days in a row without creditable prescription drug coverage and I 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
(REQUIRED) _____ **DATE** _____

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