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 RETIREE is enrolling in TRS MEHP. If RETIREE enrolled currently, leave blank.

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

SPOUSE INFORMATION

Complete this section if SPOUSE is enrolling in TRS MEHP. If SPOUSE enrolled currently, leave blank.

Spouse Name	**Spouse** Social Security Number	**Spouse** Date of Birth
Retiree Social Security Number or TRS 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 working and eligible for health insurance through an employer that participates in one of the Kentucky state retirement systems are not eligible for health insurance through TRS. Retirees and or spouses can enroll in TRS coverage within 30 calendar days of losing employer coverage. The state retirement systems are TRS; Kentucky Public Pensions Authority (KPPA) for state, county and state police employees; and Judicial Form Retirement System (JFRS) for judges and legislators.

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 TRS MEHP. If RETIREE enrolled currently, leave blank.	
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)**

Complete if SPOUSE is enrolling in TRS MEHP. If SPOUSE enrolled currently, leave blank.	
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)**

DEMOGRAPHIC INFORMATION (REQUIRED)		
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 will not be eligible for health insurance through an employer that participates in one of the Kentucky state retirement systems (TRS, KPPA or JFRS) when the TRS MEHP coverage begins.
- 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 do not 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** _____