

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

Retirement Date

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 ENROLLMENT - Complete if enrolling in the TRS MEHP

Retiree Name

Retiree Social Security/Member ID

Date of Birth

Gender:

 Male Female

I **waive** coverage through the TRS MEHP.

SPOUSE ENROLLMENT - Complete if enrolling in the TRS MEHP

Spouse Name

Spouse Social Security Number

Date of Birth

Retiree Social Security/Member ID

Gender:

 Male Female

I **waive** coverage through the TRS MEHP. I understand by waiving this coverage, I will not be permitted to enroll in the future unless I experience a valid TRS qualifying event.

If proof of your Medicare Part B (medical) coverage is not provided to this office before the MEHP enrollment date, you will not be enrolled in coverage through TRS. Also, now or in the future, 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 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.



Continued on page 2.
Reverse side must be completed.

Use your Medicare card to complete this form and return the form and a copy of the card to TRS for MEHP enrollment. If you have applied but not yet received your Medicare card, you must contact your local Social Security office to request your Medicare claim number and effective dates for Medicare Parts A (hospital) and B. Then, upon receiving your Medicare card, you must forward a copy to TRS.

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

RETIREE INFORMATION - if enrolling in the TRS MEHP			
Retiree Name	Social Security Number	Married <input type="checkbox"/> YES <input type="checkbox"/> NO	Date of Birth
Medicare Claim Number	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			

SPOUSE INFORMATION - if enrolling in the TRS MEHP			
Spouse Name	Social Security Number	Married <input type="checkbox"/> YES <input type="checkbox"/> NO	Date of Birth
Medicare Claim Number	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			

By signing below, I confirm I have read and understand all the enclosed documents/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 _____