

**TRS-ACTIVECARE
DECLINATION CERTIFICATION
New Caney ISD - Group #085000-1653**

This is to certify that the available health coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage as indicated below. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage as well as a preexisting condition exclusion period (not applicable to HMO coverage).

Name		Reason for Declining Coverage
<input type="checkbox"/> Employee Name _____	Social Security No ____/____/____	<input type="checkbox"/> Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, explain
<input type="checkbox"/> Spouse Name _____	Social Security No ____/____/____	<input type="checkbox"/> Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, explain
<input type="checkbox"/> Dependent Child _____	Social Security No ____/____/____	<input type="checkbox"/> Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, explain
<input type="checkbox"/> Dependent Child _____	Social Security No ____/____/____	<input type="checkbox"/> Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, explain
<input type="checkbox"/> Dependent Child _____	Social Security No ____/____/____	<input type="checkbox"/> Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, explain
<input type="checkbox"/> Dependent Child _____	Social Security No ____/____/____	<input type="checkbox"/> Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, explain

Name (Printed): _____

Signature: _____

SSN: _____

Date _____

**Please mail completed form to:
Blue Cross & Blue Shield of Texas
TRS-ActiveCare
P.O. Box 660400
Dallas, Texas 75266-0400**