

**\*\*\*COMPLETE IF YOU ARE DECLINING MEDICAL COVERAGE\*\*\***

**TRS-ACTIVECARE  
DECLINATION CERTIFICATION  
Arlington ISD - Group #085000-0339**

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).

<b>Name</b>		<b>Reason for Declining Coverage</b>
↑ Employee Name	Social Security No _____/____/_____	↑ Other Group Coverage ↑ Medicare ↑ Medicaid ↑ Other, explain
↑ Spouse Name	Social Security No _____/____/_____	↑ Other Group Coverage ↑ Medicare ↑ Medicaid ↑ Other, explain
↑ Dependent Child	Social Security No _____/____/_____	↑ Other Group Coverage ↑ Medicare ↑ Medicaid ↑ Other, explain
↑ Dependent Child	Social Security No _____/____/_____	↑ Other Group Coverage ↑ Medicare ↑ Medicaid ↑ Other, explain
↑ Dependent Child	Social Security No _____/____/_____	↑ Other Group Coverage ↑ Medicare ↑ Medicaid ↑ Other, explain
↑ Dependent Child	Social Security No _____/____/_____	↑ Other Group Coverage ↑ Medicare ↑ Medicaid ↑ 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**