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).

Name	Reason for Declining Coverage
☐ 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