



Please print in blue or black ink.

Group Number 085000

www.trr.state.tx.us/trr-activecare

Toll-Free Customer Service 1.866.355.9999

This form is to be completed by both husband and wife who wish to split the cost of employee and spouse or employee and family coverage while being employed by different districts/entities participating in TRR-ActiveCare.

The employee identified in Section 1 is required to select a plan under TRR-ActiveCare. The employee's spouse, identified in Section 3, is required to decline (waive) TRR-ActiveCare coverage. The employing district/entity for EACH person must also complete Sections 2 or 4, as appropriate.

The cost for TRR-ActiveCare coverage will be split between the two employers. Each employer will be billed 50 percent of the total cost of the TRR-ActiveCare plan selected by the employee in Section 1.

The entity employing the spouse who declined coverage will consider the employee as covered under a group health plan for funding purposes.

SECTION 1 — TO BE COMPLETED BY EMPLOYEE that has elected employee and spouse or employee and family coverage

Employee Last Name	First Name	Middle Initial	Social Security Number
			-
I have elected employee and spouse or employee and family coverage, and I elect to split the cost of coverage 50/50 with my spouse.			
Employee Signature			Date

SECTION 2 — TO BE COMPLETED BY EMPLOYER of the employee in Section 1

District/Entity Name	TRR Reporting Number
I confirm this employee is an active employee enrolled for TRR-ActiveCare coverage. I understand that the cost of this employee's coverage will be split 50/50 between our district/entity and the participating district/entity of the employee's spouse.	
Employer Verification Signature	Effective Date
Date	

SECTION 3 — TO BE COMPLETED BY EMPLOYEE that will be declining coverage

Employee Last Name	First Name	Middle Initial	Social Security Number
			-
I elect to split the cost of coverage 50/50 with my spouse. I have declined TRR-ActiveCare coverage under my participating district/entity and will be covered as a dependent of my spouse as listed in Section 1.			
Employee Signature			Date

SECTION 4 — TO BE COMPLETED BY EMPLOYER of the employee in Section 3

District/Entity Name	TRR Reporting Number
I confirm this employee is an active employee who has declined TRR-ActiveCare coverage. I understand that 50 percent of the cost of coverage elected by this employee's spouse will be billed to our district/entity.	
Employer Verification Signature	Date

SECTION 5 — TO BE COMPLETED BY EMPLOYER of the employee in Section 3 to TERMINATE SPLIT PREMIUM

District/Entity Name	TRR Reporting Number
Please terminate the split premium funding arrangement for this employee.	
Employer Verification Signature	Effective Date
Date	