



CT TEACHERS' RETIREMENT BOARD
765 ASYLUM AVENUE HARTFORD, CT 06105-2822
Toll Free 1-800-504-1102 X8411 or X8432 (860) 241-8411 or 860-241-8432 Fax (860) 622-2849
"An Affirmative Action/Equal Opportunity Employer"
www.ct.gov/trb

HEALTH INSURANCE APPLICATION

Mandatory Eligibility Requirements

- Participation in Medicare Part A and Medicare Part B
- A member collecting a retirement benefit or a disability allowance, or
- A spouse of a retired member, or
- A surviving spouse who has not entered into another marriage, or
- A disabled dependent of a member collecting a retirement benefit or a disability allowance, if there is no spouse or surviving spouse.

Mandatory Filing Requirements

- Proof of participation in Medicare Part A and Medicare Part B (a copy of Medicare Card or a letter from Social Security providing the Medicare Claim Number and the effective dates for Medicare Part A and Medicare Part B)
- Copy of a marriage certificate from spouse
- If the application includes coverage for a disabled dependent, a copy of the member's most recent federal income tax return documenting the disabled dependent's status as the member's dependent
- One form per enrollee must be received by the 25th of the 2nd month preceding the effective date of coverage.

Changing Your TRB Coverage

- You may not change your coverage until the next open enrollment period, held each October, effective the following January.
- You may cancel all coverage at any time and may reenroll during the next open enrollment period.

Important Information Regarding Our Plan

- **DIABETIC SUPPLIES (Test Strips, Lancets, and Monitors)** are available through a retail pharmacy or through a diabetic supply company. Claims should be submitted through both Medicare and Stirling Benefits, as these items are not covered under your pharmacy benefits program.
- Plan Members who receive the **Shingles Vaccine** on or after January 1, 2013 may receive partial reimbursement under the medical plan administered by Stirling Benefits, Inc. Contact Stirling Benefits to obtain claim forms. Vaccinations received prior to January 1, 2013 are not subject to this provision.
- The cost of prescriptions varies from one pharmacy to another, therefore, if you use a retail pharmacy we encourage you to shop around.
- Caremark fills mail order prescriptions received directly from your physician when they receive the prescription, regardless of whether you are aware of or have approved the order. If you get the prescription from your physician so you can order yourself, you will need to allow up to 4 weeks for processing after you submit the order. If your physician changes your prescription, you should obtain confirmation from Caremark that the original prescription will be cancelled. A change in dosage does constitute a prescription change.
- We receive a federal reimbursement for sponsoring a prescription program for retirees who are enrolled in Medicare. **We do not allow participation in our prescription program if you are participating in a Medicare Part D prescription program; a Medicare Advantage program, or the prescription program of another employer who also receives the federal reimbursement.** If you enroll in our health care plan and we learn that you are participating in any of the above programs, your TRB prescription coverage will be discontinued and there will be no reduction or refund of your TRB premium. You would only be allowed back into the TRB prescription coverage during the next open enrollment period provided you submit evidence that

you have cancelled your other prescription coverage. To find out if another prescription program receives the federal reimbursement you must contact the provider of that coverage.

- A spouse is no longer eligible for TRB coverage upon divorce or legal separation. In the event a former spouse is participating in the TRB sponsored health insurance plan, the member must inform TRB and provide a copy of the legal separation or the dissolution of marriage to avoid reimbursement of paid claims for the ineligible spouse.
- A surviving spouse is no longer eligible upon remarriage. Prompt notification is necessary to avoid reimbursement of paid claims after eligibility ends.
- TRB submits current addresses to the health plan vendors on the 1st working day of each month. You must submit address changes in writing, including your signature, directly to us at the above address.
- The annual prescription deductible of \$250 begins on January 1st and is not prorated when you participate for a portion of the year. Members enrolling late in the year are subject to the full \$250 deductible in the year they enroll and are also subject to the full \$250 deductible in the new year which begins the following January. For example, if joining the plan on December 1st, there is a deductible that would apply for December that would be renewed for January 1st, since these two months fall in different calendar years.

The services covered under the Connecticut State Teachers' Retirement Board Health Benefits Plan are described in the Health & Prescription Drug Benefits Plan Summary bulletin available on our website: <http://www.ct.gov/trb/lib/trb/formsandpubs/SPD-WEB.pdf>

PLAN SPONSOR INFORMATION

Connecticut Teachers' Retirement Board
765 Asylum Avenue
Hartford, Connecticut 06105-2822
Direct-Dial (860) 241-8411
Toll-Free (800) 504-1102 <http://www.ct.gov/trb>

MEDICAL CLAIMS ADMINISTRATOR

Stirling Benefits, Inc.
20 Armory Lane
Milford, Connecticut 06460-3361
(800) 447-6689 <http://www.stirlingbenefits.com/>

PRESCRIPTION DRUG SERVICES

CVS Caremark
PO Box 94467
Palatine, IL 60094-4467
e-mail customerservice@caremark.com
(877) 906-3802 <https://www.caremark.com>

DENTAL CLAIMS ADMINISTRATOR

Aetna Dental PPO II
151 Farmington Avenue
Hartford CT 06156
(855) 394-3874 <http://www.aetna.com>

Retain This Important Document for Future Reference



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Member Health Insurance Application

- A photocopy of your Medicare Card, or a letter from Social Security providing your Medicare membership number and effective date of your coverage under Medicare Part A and Medicare Part B, must be submitted with this application.
- We must receive your application by the 25th of the 2nd month preceding the effective date of coverage. (e.g., by February 25th for coverage to be effective April 1st)
- You may not change your coverage until the next open enrollment period.
- You may cancel all coverage at any time and may reenroll during the next open enrollment period.
- The annual prescription deductible is on a calendar year basis, from January to December. Members enrolling during the year are subject to the full \$250 deductible for the year in which they enroll; a new deductible would begin the following January.
- Premiums are deducted monthly from your retirement benefit.

I elect to have the following coverage become effective _____ /01/ _____

	Cost per person per month	Check one
Medicare Supplement with Prescriptions	\$97.00	<input type="checkbox"/>
Medicare Supplement with Prescriptions and Dental	\$141.00	<input type="checkbox"/>
Medicare Supplement with Prescriptions and Dental, Vision & Hearing	\$146.00	<input type="checkbox"/>

Enrollee's Last Name	First Name	Initial	Home Phone	Gender <input type="checkbox"/> Male or <input type="checkbox"/> Female
Street Address		City	State	Zip Code
Social Security Number		Date of Birth		Email Address
Enrollee's Signature			Date	



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Spouse, Surviving Spouse or Disabled Dependent Health Insurance Application

- A photocopy of your Medicare Card, or a letter from Social Security providing your Medicare membership number and effective date of your coverage under Medicare Part A and Medicare Part B, must be submitted with this application.
- A photocopy of a marriage license.
- A spouse becomes ineligible upon legal separation or divorce.
- A surviving spouse becomes ineligible upon remarriage.
- If the application includes coverage for a disabled dependent, a copy of the member's most recent federal income tax return documenting the disabled dependent's status as the member's dependent is required.
- We must receive your application by the 25th of the 2nd month preceding the effective date of coverage. (e.g., by February 25th for coverage to be effective April 1st)
- You may not change your coverage until the next open enrollment period.
- You may cancel all coverage at any time and may reenroll during the next open enrollment period.
- The annual prescription deductible is on a calendar year basis, from January to December. Members enrolling during the year are subject to the full \$250 deductible for the year in which they enroll; a new deductible would begin the following January.

I elect to have the following coverage become effective _____ /01/ _____

	Cost per person per month	Check one
Medicare Supplement with Prescriptions	\$97.00	<input type="checkbox"/>
Medicare Supplement with Prescriptions and Dental	\$141.00	<input type="checkbox"/>
Medicare Supplement with Prescriptions and Dental, Vision & Hearing	\$146.00	<input type="checkbox"/>

Enrollee's Last Name	First Name	Initial	Home Phone	Gender <input type="checkbox"/> Male or <input type="checkbox"/> Female
Street Address		City	State	Zip Code
Social Security Number	Date of Birth		Email Address	
Enrollee's Signature			Date	

If you are enrolling as the spouse or the disabled dependent of a retired teacher, please have the retiree sign below:

Retired Teacher's Name	Retired Teacher's Social Security Number	Retired Teacher's Signature
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