



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.
- You must be a legal resident of the United States to participate in the TRB health plan.

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 I.D. Number and the effective dates for Medicare Part A and Medicare Part B)
- Copy of a marriage certificate or a marriage license from spouse, if enrolling
- 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.

Cancelling Your TRB Coverage

You may cancel all coverage at any time; however you will not be able to reenroll for two years.

Important Information Regarding Our Plan

- Our health care coverage is offered as a single package which includes Hospital, Medical, Major Medical, Prescription Drug Benefits and Dental, Vision & Hearing. The cost of the package in 2016 is \$148 per month per person.
- The federal government will only subsidize one prescription plan for you at a time. If we are notified that you are participating in another prescription plan subsidized and/or paid for by the federal government all of your health care coverage through the TRB will be terminated.
- The cost of prescription drugs varies from one pharmacy to another, therefore, if you use a retail pharmacy we encourage you to shop around.

- The annual prescription deductible of \$360 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 \$360 deductible in the year they enroll and are also subject to the full \$360 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 maximum per member annual dental limit is increasing from \$2,000 to \$2,500 effective January 1, 2016.
- A spouse is not 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 dissolution of marriage as soon as possible.
- A surviving spouse is not eligible upon remarriage. Prompt notification is required.
- The TRB provides address changes to all of our health plan vendors. You must maintain your current address with us at all times to ensure as little disruption as possible in the delivery of services and the processing of claims.

The Health & Prescription Drug Benefits Plan Summary is available on our website at:

<http://www.ct.gov/trb/lib/trb/formsandpubs/SPD-WEB.pdf>.

MEDICAL CLAIMS ADMINISTRATOR

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

PRESCRIPTION DRUG SERVICES

Express Scripts
One Express Way
St. Louis, MO 63121
(844) 433-4883 www.express-scripts.com

DENTAL CLAIMS ADMINISTRATOR

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

PLAN SPONSOR INFORMATION

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

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 cancel all coverage at any time; reenrollment will be subject to all plan coverage, including dental, vision and hearing.
- The annual prescription deductible is on a calendar year basis, from January to December. Members enrolling during the year are subject to the full \$360 deductible for the year in which they enroll; a new deductible would begin the following January.
- Premiums are deducted monthly from your retirement benefit.

	Cost per person per month	Effective Date
Medicare Supplement with Prescriptions and Dental, Vision & Hearing	\$148.00	

Enrollee's Last Name, First Name, Initial		Home Phone		Gender	
				Male	Female
<input type="checkbox"/>		<input type="checkbox"/>			
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 or a marriage certificate.
- 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 cancel all coverage at any time; reenrollment will be subject to all plan coverage, including dental, vision and hearing.
- The annual prescription deductible is on a calendar year basis, from January to December. Members enrolling during the year are subject to the full \$360 deductible for the year in which they enroll; a new deductible would begin the following January.

		Cost per person per month	Effective Date
Medicare Supplement with Prescriptions and Dental, Vision & Hearing		\$148.00	
Enrollee's Last Name, First Name, Initial		Home Phone	
		Male	Female
<input type="checkbox"/>	<input type="checkbox"/>		
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 #	Retired Teacher's Signature