TEACHERS' RETIREMENT BOARD
165 Capitol Avenue
Hartford, CT 06106-1673
Healthinsurance.TRB@ct.gov

Toll free: 1 (800) 504-1102
Website: www.ct.gov/trb
Fax #: 860-622-2849

HEALTH INSURANCE APPLICATION 2025

PLEASE READ ALL INFORMATION ON PAGE 2

Last Name:	First Name:	M.I.	Date of Birth:	Social Security Number:

Gender	Select One: Male ☐ Female ☐ Other:	Relationship to TRB	Select One: Member ☐ Spouse ☐ Disabled Dependent ☐

Street Address:

Physical Address: Required if above is a PO Box

City:	State	Zip Code	Phone Number:	Personal Email:

By providing your phone number, you consent to allowing the insurance providers listed below, and their affiliates, to call the phone number(s) above using an autodialer and/or prerecorded voice technology. You may opt-out of this at any time by contacting the carrier directly.

Coverage begin date: _____ /01/_____ All coverage begins on the first of the month

Coverage Options: *(choose one)*	Cost per person per month	Select One
UnitedHealthcare Medicare Advantage Includes: Vision, Hearing, Prescriptions and Cigna Dental	$148.00	☐
UnitedHealthcare Senior Supplement Includes: Vision, Hearing, Prescriptions and Cigna Dental	$323.00	☐

As a new enrollee you have a one time option to waive dental coverage and reduce your plan cost by $54.00. If you elect to waive the coverage, you will not have the opportunity to enroll in the dental coverage at a later date unless CTRB deems otherwise. If you wish to waive the dental coverage, please check the box below.

☐ By checking this box I acknowledge I am waiving enrollment into the Cigna dental plan through CTRB and thereby forfeiting any eligibility to enroll in the dental plan offering in the future unless CTRB deems otherwise.

If you have End-Stage Renal Disease (ESRD) please complete the following information:	What is the date you first became eligible for ESRD Medicare?

Enrollee signature date cannot be more than 90 days prior to the coverage begin date entered above

Enrollee's Signature		Date:	
Retiree's Signature		Retiree SSN:	

Please attach all mandatory filing requirements noted on the next page and submit using address, fax or email provided at the top of the form

Important Information PLEASE READ

Mandatory Eligibility Requirements

To qualify for the TRB Health Plan of your choosing you must have:

- Enrollment in Medicare Part A and Medicare Part B on or before your requested effective date with TRB
- Currently be a TRB member collecting a retirement benefit or a disability allowance, **or**
    - You are the spouse of a retired member, **or**
    - You are the surviving spouse of a retired member who has not entered into another marriage, **or**
    - You are the 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

To file your Health Insurance Application for the TRB Health Plan of your choosing you must include with your completed application:

- 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). **Medicare ID Number required before enrollment is processed**. Applications received without Medicare I.D. will be pended.
- If enrollee is the spouse of a TRB member, please provide a copy of a marriage certificate or a marriage license.
- 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.
- If more than one enrollee, please provide one form per enrollee.
- Submit application with signature date dated no earlier than 90 days. Submitting application at least 30 days prior to requested coverage begin date is recommended to avoid delay in receiving physical membership cards. A letter will be sent via email once the application is processed.

Important Information Regarding Our Plan

- Our health care coverage is offered as a package which includes Hospital, Medical, Major Medical, Prescription Drug Benefits and Dental and Vision & Hearing for the price indicated on page 1. You may elect to waive dental at enrollment, but you will not have the option to enroll in the dental plan at a later date. Price breakdowns are available on our website with and without dental coverage.
- All plans are on a calendar year basis. Deductibles renew on January 1 of each calendar year and are not pro-rated based on when you enroll.
- Some members may be required to pay an extra amount for Part B and Part D because of their yearly income. This is known as the Income-Related Monthly Adjustment Amount (IRMAA) and it is paid directly to the federal government not to the TRB. For more information on IRMAA, you can visit the Medicare website: http://www.medicare.gov or call Medicare at 800-633-4227.
- Premiums for the TRB Sponsored plan of your choice are deducted from the retiree's pension benefit at the end of the month preceding the covered month.
- A spouse is not eligible for TRB coverage upon divorce or legal separation. Prompt notification with a copy of legal separation or dissolution of marriage is required.
- 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.
- If a member is reemployed as a public-school teacher following their retirement, the member (and spouse or dependent) can elect to continue their TRB health plan coverage while reemployed, but at no additional charge.

Detailed Plan Summaries are available online