SECTION D – ACKNOWLEDGEMENT AND ACCEPTANCE

I acknowledge receipt of the instructions for completing this form. I certify that the information on this form is true and complete to the best of the knowledge. I understand that giving false information on this form may result in loss of coverage.

I acknowledge that my confidential information may be disclosed to third parties that assist TRP in connection with the administration of the health plan in which I am enrolled.

Information collected on this form includes my telephone number and my cell phone number, if provided. I understand that this information will also be provided to third parties in connection with health plan administration. I consent to calls or texts at these numbers and I understand that the calls I receive could be automated. **I understand that I can cancel this consent to receiving calls and texts at these numbers at any time** without affecting my eligibility for benefits, enrollment and coverage, and without affecting my ability to get treatment. Upon request, TRP will provide me the identity of the third parties that may be communicating with me at these phone numbers and I may contact those third parties directly regarding the use of my phone numbers. I also understand that data use charges and rates from my cellular carrier may apply.

I authorize the Teacher Retirement Pension (TRP) to withhold from my monthly annuity and remit to TRP-Care any amount necessary to cover my share of the cost of coverage. If the amount of the annuity is not sufficient to cover the cost of the coverage, or if I am not receiving a monthly annuity, I understand that TRP-Care or the TRP-Care administrator will bill me, and I will send payment on a timely basis. I understand that failure to pay my full premium amount timely may result in (1) termination of my coverage and (2) termination of coverage for any of my eligible dependents.

I understand that a TRP service retiree or a TRP disability retiree who meets the TRP-Care eligibility, may apply for health care coverage under TRP-Care. I understand that the individuals that I am enrolling as dependents must meet the TRP-Care eligibility criteria for dependents as defined by TRP-Care. I understand that a service retiree under the TRP retirement plan who is eligible for another state group health plan as an employee or retiree of either the State of Texas or a Texas public college or university is not eligible to participate in TRP Care. I agree to notify TRP-Care immediately if such eligibility occurs in the future. I understand that if I am uncertain about whether I am eligible for coverage under TRP-Care, I should contact TRP Health & Insurance Benefits at 1 (888) 237-XXXX before signing and submitting this application. I certify that I am, and any dependents that I am enrolling, are eligible to participate in TRP-Care.

Please note that future plan options may change.

This form does not serve as a change of beneficiary of TRP retirement, death, or survivor benefits.

PLEASE BE SURE TO SIGN THIS FORM BELOW BEFORE IT IS RETURNED

_____ _____

Signature of Retiree **Date**

Make a copy for your record and return to the address below.

TRP Health & Insurance Benefits
Teacher Retirement Pension
1XXX Red River Street, Austin, Texas 78701-2698
Telephone 1 (888) 237-XXXX