

Please print in blue or black ink.

Group Number 085000

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

1. District/Entity Name _____
2. TRS Reporting Number
3. Effective Date with TRS-ActiveCare _____
4. Address _____

5. Contact Name _____
6. Contact Person Phone Number (_____) _____
7. Internet/E-mail Address (if available) _____
8. **Attach** a complete list of COBRA participants or dependents, including all information listed below. (Normally all this information is found on reports that can be obtained from your existing COBRA vendor.)

PARTICIPANT DEPENDENT (S)	PARTICIPANT DEPENDENT (S)
Name	Name
Address	Social Security Number
Phone Number (if available)	Date of Birth
Social Security Number	Type of Coverage Elected
Date of Birth	
Qualified Event Date	
Qualified Event Reason	
Current Paid to Date of COBRA Premiums	
Type of Coverage Elected	

9. Name/Contact of Prior COBRA Administrator Vendor (if applicable) _____

Signature _____ Date _____
(Form completed by)

If you have any questions on how to complete this form, please contact Health Care Service Corporation at 1-888-541-7107. Our hours of operation are Monday through Friday, 7:30 a.m. till 5:00 p.m. (Central Time).

Please return completed form and any additional documentation to:

Health Care Service Corporation
COBRA Administration
P.O. Box 1180
Marion, IL 62959-7680

E-mail: COBRA@bcbsil.com
FAX: (618) 998-2747