IRVING
Independent School District

POOLED APPLICATION

This is to be completed by both husband and wife, who are Irving ISD employees and wish to take advantage of a combined district contribution and enroll in either employee and spouse or employee and family coverage.

- **Section 1 will include name of primary/carrying employee and signature acknowledgement**
- **Section 2 will include name of declining employee and signature acknowledgement**
- **Section 3 will included selected plan under TRS-ActiveCare**
- **The pooled premium election will remain in place until section 4 is completed and signed by both parties.**

Note: If district is not notified, premiums for non-pool coverage will be retroactively collected for the months employee was ineligible for Pool coverage

Section1 – TO BE COMPLETED BY PRIMARY/CARRYING EMPLOYEE			
Last Name	First Name	Middle Initial	Employee Number
I have elected to enroll in a coverage that will enable me to carry my spouse who is also an employee of Irving ISD. I understand it is my responsibility to notify the district if either I or my spouse becomes ineligible for district contribution. I understand that I will be responsible for premiums owed. Employee Signature Date			

Section2 – TO BE COMPLETED BY DECLINING EMPLOYEE			
Last Name	First Name	Middle Initial	Employee Number
I have elected to decline coverage because my spouse, an employee of Irving ISD, will be carrying me as a dependent under TRS ActiveCare coverage. I understand it is my responsibility to notify the district if either myself or my spouse becomes ineligible for district contribution. I understand that I am responsible for premiums owed. Employee Signature Date			

Section 3 – HEALTH PLAN ELECTION	
☐ActiveCare 1 HD ☐ ActiveCare SELECT ☐ ActiveCare 2 ☐ Scott & White HMO	☐ Employee + Family

Section4 – REQUEST TO DISCONTINUE POOLED PREMIUM EFFECTIVE DATE: _____			
Last Name	First Name	Middle Initial	Employee Number
I am requested to remove pooled coverage for the upcoming plan year. Employee Signature Date			
Last Name	First Name	Middle Initial	Employee Number
I am requested to remove pooled coverage for the upcoming plan year. Employee Signature Date			