



# TEACHERS HEALTH TRUST

## TWO-CCSD EMPLOYEE ENROLLMENT FORM

**Complete this section if you or your spouse/domestic partner are currently enrolled in a Teachers Health Trust plan.**

Name: \_\_\_\_\_ SS/ID#: \_\_\_\_\_

- I wish to become or remain the primary policyholder of the Teachers Health Trust plan and transfer my spouse or domestic partner and other dependent(s), if any, under my health insurance policy. I have completed all applicable sections of the enrollment form or the change form.
- I wish to become or remain as a dependent on my spouse or domestic partner's health insurance policy. I have completed the "employee information" section only of the enrollment form to designate my life insurance beneficiary. I understand that I still have \$50,000 term life insurance through the Teachers Health Trust.
- I wish to have a separate health insurance policy from my spouse. Our dependent(s), if any, will be covered under \_\_\_\_\_ my policy \_\_\_\_\_ my spouse's policy. I have completed all applicable sections of the enrollment form.

Spouse/Domestic Partner

Name: \_\_\_\_\_ SS/ID#: \_\_\_\_\_

**Complete this section if you are not enrolled in a Teachers Health Trust plan.**

Name: \_\_\_\_\_ SS/ID#: \_\_\_\_\_

My spouse/domestic partner is currently enrolled in:

- Support Staff Plan
- Administrator Plan
- Teachers Health Trust Plan

- I wish to become a dependent on my spouse or domestic partner's plan. I have completed the "employee information" section only of the enrollment form to designate my life insurance beneficiary.
- I wish to become a primary policyholder of the Teachers Health Trust plan and transfer my spouse or domestic partner and other dependent(s), if any, under my health insurance policy. I have completed all applicable sections of the enrollment form.
- I wish to have a separate health insurance policy from my spouse or domestic partner. Our dependent(s), if any, will be covered under \_\_\_\_\_ my policy \_\_\_\_\_ my spouse's policy. I have completed all applicable sections of the enrollment form.

Spouse/Domestic Partner

Name: \_\_\_\_\_ SS/ID#: \_\_\_\_\_

**I UNDERSTAND THAT IF MY EMPLOYMENT OR MARITAL STATUS CHANGES, IT IS MY RESPONSIBILITY TO NOTIFY THE TRUST IMMEDIATELY.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Primary policyholder)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Spouse/domestic partner)