

Teachers Health Trust

Subscriber Name: _____

Subscriber ID Number: _____

Dependent Name: _____

Dependent Address: _____

Is your dependent a student at a College, University or other Educational Institution? Yes _____ No _____

Name and address of the College, University or Educational Institution: _____

Is your dependent employed? Yes _____ No _____

Name and address of Dependent's Employer: _____

Is health coverage available through the dependent's employer? Yes _____ No _____

By my signature below, I certify that the above-named dependent is not eligible to enroll in his or her own employer-sponsored health plan coverage. I understand that if such coverage becomes available, I am required to notify the Teachers Health Trust (Trust) within 31 days of the coverage eligibility date and that my dependent will no longer be eligible for coverage by the Trust. I understand if I fail to notify the Trust within the required time period, I will forfeit all premiums paid. Additionally, I will be responsible for reimbursing the Trust for any claims that were paid on behalf of the dependent while he or she was ineligible for coverage.

Signature

Date

