



Teachers Health Trust

P.O. Box 96238, Las Vegas, Nevada 89193-6238

Providing Service to Participants at: 2950 East Rochelle Avenue, Las Vegas, Nevada 89121

Phone: (702) 794-0272

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E-mail Address: serviceteam@teachershealthtrust.org

Date: _____

Employee: _____

Identification/Social Security Number: _____

Student's Name: _____

Social Security Number: _____

My dependent, _____, will not meet the Trust's requirement as a full-time student for the _____ semester.

I understand that because my dependent is not a full-time student, he/she will no longer be eligible for coverage as a dependent on my health plan but that I may elect to continue his/her coverage under COBRA.

I also understand that if my dependent meets the Student Status requirement at a later time, I can contact the Teachers Health Trust within 31 calendar days of the beginning of the semester to apply for re-enrollment.

Signature

Date