



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

Fax: (702) 794-2093

E-mail Address: serviceteam@teachershealthtrust.org

Date _____

:

Employee: _____

Identification Number/SS#: _____

Student's Name: _____

Student's Social Security Number: _____

I certify that I am providing 50% or more of the support for my dependent who is a full-time student (enrolled with at least 12 credit hours per semester or quarter or full-time as defined by the educational institution being attended). I acknowledge that it is my responsibility to notify the Trust when I am no longer providing support for my dependent, or when my dependent is no longer meets the Trust's eligibility requirements as a full-time student.

Signature

Date

I certify that my dependent no longer meets the eligibility requirement for coverage under the student status provision of the Teachers Health Trust plan. I understand that Teachers Health Trust coverage for my dependent will terminate February 28, 2007. I also understand that my dependent will be eligible to continue coverage through COBRA.

Signature

Date