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

Dear Participant:

Teachers Health Trust records indicate that your never-married dependent child, , exceeds 19 years of age. In order for your dependent(s) to be eligible as a full-time student under the Teachers Health Trust, it will be necessary for you to provide the Trust with the enclosed affidavit certifying that your dependent is a full-time student, and you are providing 50% or more of the support for your dependent.

The definition of a full-time student under the Teachers Health Trust plan is enrollment in at least 12 credit hours per semester or quarter or full-time as defined by the educational institution being attended.

You are not required at this time to submit records from the college/university; however, the Trust reserves the right to require documentation from the college/university if eligibility is of concern. All dependents covered under the Teachers Health Trust as full-time students are required to obtain the certified documentation from the college/university or authorized agent of the school each fall semester in order to continue coverage to the age of 26 years. You will receive notification from the Trust when documentation is required.

If your dependent is mentally and/or physically handicapped, causing him/her to be incapable of self-sustainment, and is solely dependent upon you (as defined by IRS Tax Rules), additional documentation is required. Please call 866-6111 and select option 6 to request the appropriate forms.

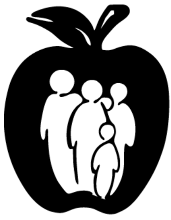
Please return by U.S. mail or fax the signed affidavit to the Teachers Health Trust by February 9, 2007. Teachers Health Trust coverage for dependents who are no longer eligible or for dependents who do not submit the affidavit will terminate on February 28, 2007. **Once the appropriate documentation is received, the Trust will send you a confirmation letter. If you do not receive a confirmation letter, please call the Trust office to confirm that your documents were received. It is your responsibility to confirm that the documentation has been received by the Trust. If your dependent's coverage is terminated, he/she may be eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). An election form and information regarding COBRA coverage will be sent directly to your dependent.**

If you have any questions or require additional information, please contact the Service Department at 794-0272 or 800-432-5859 between 8:00 a.m. and 5:00 p.m., Monday through Thursday, and 9:00 a.m. and 4:30 p.m., Friday. You may also e-mail the Service Team at serviceteam@teachershealthtrust.org.

Sincerely,

Service Department
Teachers Health Trust

Enclosure



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

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

COORDINATION OF BENEFITS

Employee:

Do you and/or your dependents have health coverage other than through the Health Trust? Please check the correct line.

______ **NO**, I only have health coverage through the Health Trust.

______ **NO**, my dependents only have health coverage through the Health Trust.

If you mark "No" above for all family members, please stop here and sign and date below.

I certify that the information supplied above is true, correct, and complete. I will notify the Health Trust when my family members' medical, dental, or prescription plans change. I authorize the Health Trust to verify any information contained on this form.

Signature ______________________ Date ______________

______ **YES**, I have health coverage through another plan.

Please complete the information requested below, sign and date.

This coverage is Active ___ Retired ___ or Medicare Part A and/or B ___

______ **YES**, my dependents have health coverage through another plan.

Please complete the information requested below, sign and date.

This coverage is Active ___ Retired ___ or Medicare Part A and/or B ___

MEDICAL

Name & phone number of employer sponsoring this plan:

____

Name & phone number of insurance carrier:

____

Name of policyholder and date of birth:

____

Individuals covered under this plan:

____

Effective Date of Coverage:

____

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

DENTAL

Name & phone number of employer sponsoring this plan:

Name & phone number of insurance carrier:

Name of policyholder and date of birth:

Individuals covered under this plan:

Effective Date of Coverage:

PRESCRIPTION

Name & phone number of employer sponsoring this plan:

Name & phone number of insurance carrier:

Name of policyholder and date of birth:

Individuals covered under this plan:

Effective Date of Coverage:

If there is more than one insurance plan/carrier, please list all information on an additional form.

I certify that the information supplied above is true, correct, and complete. I will notify the Health Trust when my family members' medical, dental, or prescription plans change. I authorize the Health Trust to verify any information contained on this form.

Signature

Date