



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

STUDENT STATUS VERIFICATION

Date: _____

Employee:

Identification Number/SS#:

Student's Name:

Name and Address of College, University, or Educational Institution:

Is the above student considered full time? Yes No

Semester/Term:

Dates of Semester/Term:

Number of Credits:

Signature of Registrar

Date

(OFFICIAL UNIVERSITY SEAL)

The Teachers Health Trust will accept this form, or a comparable form or letter, from the school or an authorized agent of the school as verification of school enrollment.

EMPLOYEE CERTIFICATION OF DEPENDENT ELIGIBILITY

I, , certify that I am providing 50% or more of the support for my dependent who has met the Trust's Student Status requirements. 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 Student Status requirements of the Trust.

Signature

Date



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STUDENT STATUS REQUIREMENTS NOT MET

Date: _____

Employee:

Identification/Social Security Number:

Student's Name:

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

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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:



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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