



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 financial 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 financial support for my dependent or when my dependent 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/Fall semester (circle one).

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 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 a semester to apply for reenrollment.

Signature

Date