Teachers Health Trust

Enrollment Form

OFFICE USE ONLY					
Eff Date	________	SGR Code	________	PLN Code	________
CCSD Code	________	Amount	________		

Social Security Number	Name (Last, Middle, First)	Birth Date

Home address	City	State	Zip Code	Sex

Primary Phone	E-mail (Personal Only)

Work Location	Hire Date

Patient Centered Medical Home Information

Main Subscriber	Internal Medicine/Family Practice	OB/GYN

Spouse/Domestic Partner	Birth Date	Internal Medicine/Family Practice	OB/GYN

☐ **Hospital Supplement:** Please check this box if you prefer to opt for Hospital Supplement instead of the Performance Plus Plan. The Hospital Supplement option is NOT available to dependents.

Dependent Coverage

Dependent (Name/Relationship)	Birth Date	SSN	Internal Medicine/ Family Practice	OB/GYN	Pediatrician

If you and your dependents(s) are currently enrolled in a plan offered by the Teachers Health Trust, eligibility documentation is not required.

Two CCSD Employees

If you are married or a domestic partner to any of the following, please indicate and provide that person's name and Social Security number.

☐ Teacher/Licensed Employee ☐ Support Staff/School Police Employee ☐ Administrator

Spouse/Domestic Partner Name	Social Security Number

Section 125 Premium-Only Plan

☐ Yes, I wish to enroll in the tax-saving Section 125 Premium-Only Plan.
☐ No, I do not wish to enroll in the tax-saving Section 125 Premium-Only Plan at this time.

I have read both sides of this form and understand I have 31 calendar days from the effective date of my coverage to make plan changes.

This enrollment form revokes any prior enrollment form completed and will remain in effect and cannot be revoked or changed during the calendar year, unless the revocation and new enrollment are due to and consistent with a change in family status (e.g., marital status, death, birth, adoption, changes in employment or student status, etc.). Please return this completed form to the Trust via fax at 702-794-2093 or e-mail at serviceteam@teachershealthtrust.org

Signature: ______________________________ Date: ______________

Life Insurance

Primary Beneficiary

Name (Last & First)	Relationship

Home address	City	State	Zip Code

Contingent Beneficiary

If the primary beneficiary named on this form predeceases you, the benefit payment will be made directly to the contingent beneficiary upon filing a claim and submitting the applicable forms and documents.

Name (Last & First)	Relationship

Home address	City	State	Zip Code

Coordination of Benefits

Spouse/Domestic Partner's Employer	Phone

Employer Address	City	State	Zip Code

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

- ☐ No, my dependent(s) and I only have health coverage through the Teachers Health Trust.
- ☐ Yes, my dependent(s) and/or I have health coverage through Another Plan.

This coverage is: ☐ Active ☐ Retired

Medical

Sponsoring Employer Name	Phone

Insurance Carrier	Phone

Policy Holder Name	Birth Date

Individuals Covered Under Plan

Policy Number	Effective Date of Coverage

Dental

Sponsoring Employer Name	Phone

Insurance Carrier	Phone

Policy Holder Name	Birth Date

Individuals Covered Under Plan

Policy Number	Effective Date of Coverage

Prescriptions

Prescription Drug Carrier Name

If applicable, please provide a copy of the divorce decree stipulating the person responsible for providing child(ren) health coverage.

I certify that the information supplied above is true, correct and complete. I understand the Teachers Health Trust may request an update of this information in the future. I further certify that I will notify the Teachers Health Trust when my family members' medical, dental or prescription plans change. I authorize the Teachers Health Trust to verify any information contained on this form.