This form must be completed if you or your spouse/domestic partner is currently enrolled in a Teachers Health Trust, Support Staff or Administrator plan.

Name: ______________________________ SS/ID#: ______________

Select the plan you are currently enrolled in:

☐ Teachers Health Trust Plan ☐ Support Staff Plan ☐ Administrator Plan

Spouse or Domestic:

Name: ______________________________ SS/ID#: ______________

Select the plan that your Spouse or Domestic Partner is currently enrolled in:

☐ Teachers Health Trust Plan ☐ Support Staff Plan ☐ Administrator Plan

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☐ I wish to become or remain the primary policy holder of the **Teachers Health Trust** plan and transfer my spouse or domestic partner and other dependent(s), if any, under my health insurance policy. I have completed all applicable sections of the enrollment/change form.

☐ I wish to become or remain a dependent on my spouse or domestic partner's Trust/Support/Administrator insurance policy. I have completed the "employee information" section only of the enrollment form to designate my life insurance beneficiary. I understand that I still have **$50,000 term life insurance through the Teachers Health Trust**.

☐ I wish to have a separate health insurance policy from my spouse or domestic partner. Our dependent(s), if any, will be covered under ☐ my policy or ☐ my spouse or domestic partner's policy. I have completed all applicable sections of the enrollment form.

Signature: ______________________________ Date: ______________
(Primary policyholder)

Signature: ______________________________ Date: ______________
(Spouse/domestic partner)

I UNDERSTAND THAT IF MY EMPLOYMENT OR MARITAL STATUS CHANGES, IT IS MY RESPONSIBILITY TO NOTIFY THE TRUST IMMEDIATELY.

WHITE: HEALTH TRUST PINK: EMPLOYEE