Teachers Health Trust
Dependent Certification Form

Subscriber Name: _____

Subscriber ID Number: _____

Dependent Name: _____

Dependent Address: _____

_____

Is your dependent a student at a college, university or other educational institution? Yes _____ No _____

Name and address of the college, university or educational institution: _____

_____

Is your dependent employed? Yes _____ No _____

Name and address of dependent's employer: _____

_____

Is health coverage available through the dependent's employer? Yes _____ No _____

Information for Dependent's Employee-Sponsored MEDICAL Plan

Name and phone number of employer sponsoring the other plan: _____
Name and phone number of insurance carrier: _____
Name of policyholder and date of birth: _____
Individuals covered under this plan: _____
Policy Number: _____
Effective date of coverage: _____

Information for Dependent's Employee-Sponsored Dental Plan

Name and phone number of employer sponsoring the other plan: _____
Name and phone number of insurance carrier: _____
Name of policyholder and date of birth: _____
Individuals covered under this plan: _____
Policy Number: _____
Effective date of coverage: _____

By my signature below, I certify that the above-named dependent may be eligible to enroll in his or her own employer-sponsored health plan coverage. I understand that if such coverage becomes available, I am required to notify the Teachers Health Trust (Trust) within 31 days of the coverage eligibility date and that my dependent's employer-sponsored health plan will be their primary coverage. The Teachers Health Trust will be the secondary coverage. I understand if I fail to notify the Trust within the required time period, I will forfeit all premiums paid. Additionally, I will be responsible for reimbursing the Trust for any claims that were paid on behalf of the dependent while he or she was ineligible for coverage.

_____ _____

Signature Date