Teachers
Health Trust

2950 East Rochelle Avenue | Las Vegas, Nevada 89121
Mailing Address: P.O. Box 96238 | Las Vegas, Nevada 89193- 6238
Phone: (702) 794-0272 Fax: (702) 794-2093
E-mail Address: serviceteam@teachershealthtrust.org

Dear Participant:

The Trust asks that you provide the information requested below. This will enable the Trust to process any claims that are received for you and any of your dependents. This letter must be returned to the Trust within 30 days of the date of this letter. Future claims for your family will not be processed until the information is received. We have provided a self-addressed stamped envelope for your convenience.

1. Is your spouse/domestic partner employed? ☐ **Yes- Complete sections A, & B** ☐ No

2. Do your DEPENDENTS have health coverage other than the Trust? ☐ **Yes- Complete sections A, & B** ☐ No

3. Do YOU have health coverage other than the Trust? ☐ **Yes- Complete sections A, & B** ☐ No

SECTION A				
My spouse/domestic partner works:	❑ **Full-time with benefits**	❑ **Full-time without benefits**	❑ Part-time **with benefits**	❑ Part-time **without benefits**
EMPLOYER:		Employer Phone: ( )		
Street address:		City:	State:	Zip:
Please answer ALL three questions:				
1. Is health insurance currently offered through his/her employer?		❑ **Yes**	❑ No	
2. Is your spouse/domestic partner eligible to enroll in health insurance through his/her employer?		❑ **Yes**	❑ No	
3. Is your spouse/domestic partner enrolled for health insurance through his/her employer?		❑ **Yes**	❑ No	

I verify that all members covered by the Teachers Health Trust meet all eligibility requirements.
I certify that the information supplied above is true, correct, and complete. **I will notify the Trust immediately when my family members' medical, dental, or prescription plan changes.** I authorize the Trust to verify any information contained on this form.

Signature _____ Date: _____/_____/_____

Email Address: _____

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SECTION B
(OTHER) INSURANCE INFORMATION

MEDICAL

This is an: (please check one box):	❑ Active Plan ❑ Retiree Plan	
Employer:		Employer Phone: ( )
Name of Insurance Carrier :		Insurance Phone: ( )
Name of Policyholder:		Date of Birth: / /
Individuals Covered Under this plan:		
Name:	Name:	Name:
Name:	Name:	Name:
Policy Number: #		**Effective Date:** / /

DENTAL

This is an: (please check one box):	❑ Active Plan ❑ Retiree Plan	
Employer:		Employer Phone: ( )
Name of Insurance Carrier :		Insurance Phone: ( )
Name of Policyholder:		Date of Birth: / /
Individuals Covered Under this plan:		
Name:	Name:	Name:
Name:	Name:	Name:
Policy Number: #		**Effective Date:** / /

PRESCRIPTION

This is an: (please check one box):	❑ Active Plan ❑ Retiree Plan	
Employer:		Employer Phone: ( )
Name of Insurance Carrier :		Insurance Phone: ( )
Name of Policyholder:		Date of Birth: / /
Individuals Covered Under this plan:		
Name:	Name:	Name:
Name:	Name:	Name:
Policy Number: #		**Effective Date:** / /