TeachersHealthTrust

Enrollment Form

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

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

Home address	City	State	Zip Code	Sex
				☐ Male ☐ Female

Home Phone	E-mail (Personal Only)

Work Location	Hire Date

☐ **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.**

Patient-Centered Medical Home Information

Primary Care Provider (PCP) (Full Name/Address)

Dependent Coverage

Dependent Name/Relationship	Birth Date	Social Security Number

Primary Care Provider (PCP) (Full Name/Address)

Dependent Name/Relationship	Birth Date	Social Security Number

Primary Care Provider (PCP) (Full Name/Address)

Dependent Name/Relationship	Birth Date	Social Security Number

Primary Care Provider (PCP) (Full Name/Address)

Dependent Name/Relationship	Birth Date	Social Security Number

Primary Care Provider (PCP) (Full Name/Address)

Two-CCSD Employees

If you are married or a domestic partner to another CCSD employee as listed below, 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

A separate enrollment form must be completed for a Two-CCSD household, please request this form from the Teachers Health Trust.

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.

Health Management Programs

The Trust provides health management programs for some chronic conditions. Do you, or any of your dependents, currently manage:

☐ Diabetes ☐ High-risk Pregnancy ☐ Asthma and/or COPD ☐ Hypertension and/or Congestive Heart Failure

Life Insurance

PrimaryBeneficiary

Name (Last, First)	Relationship

Home address	City	State	Zip Code

ContingentBeneficiary

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

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

Please fill out for dependent(s) ages 19-26

☐ No, I do not have any dependent(s) ages 19 - 26.
☐ Yes, my dependent(s) ages 19 - 26 have health coverage through another plan.

Name and address of the college, university or educational institution

Medical&DentalInformation

	Medical	Dental	Prescriptions
Insurance Carrier Name			
Insurance Carrier Phone			
Policy Holder Name			
Birth Date			
Covered Individuals			
Policy Number			
Effective Date of Coverage			

I certify that the information supplied above is true, correct and complete. I understand that 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. If applicable, please provide a copy of the divorce decree stipulating the person responsible for providing child(ren) health coverage. I authorize the Teachers Health Trust to verify any information contained on this form.

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, etc.). Please return this completed form to the Trust via fax at 702-794-2093 or e-mail at serviceteam@teachershealthtrust.org.

Signature: _____ Date: _____