



Teachers Health Trust
Insurance Waiver (Active Employees Only)

 Date

 Participant Name

 Member ID Number

 Participant Address

 City State Zip Code

Re: Teachers Health Trust Waiver

By my signature, I, _____, decline any health coverage offered by the Teachers Health Trust. I understand that by signing this statement, I am waiving my rights to the \$50,000 Term Life Insurance Policy as well as all medical, dental and vision coverage. I am also waiving all medical, dental and/or vision coverage for my dependents.

I further understand, I will be able to elect a health coverage option and resume other benefits only during a future Open Enrollment or Special Enrollment period.

Signature

Date

This statement is valid only if notarized.

STATE OF NEVADA
 COUNTY OF CLARK

The foregoing instrument was acknowledged before me this _____ day of _____, 20____, by _____, who provided proper identification.

Notary Public

My commission expires: _____