Teachers Health Trust

P.O. Box 96238, Las Vegas, Nevada 89193-6238

Providing Service to Participants at: 2950 East Rochelle Avenue, Las Vegas, Nevada 89121
Phone: (702) 794-0272 **FAX:** (702) 794-2093
E-mail Address: serviceteam@teachershealthtrust.org

Subscriber's Name: ________________________ SSN / ID Number:_____________

Address: ____
Street Address

____
City *State* *Zip Code*

By my signature below, I, _________________________________, decline any health care 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 only be able to elect a health coverage option, and resume other benefits, during a future open enrollment period.

____________________________________ ______________________
Signature of Subscriber *Date*

This statement is valid only if notarized.

STATE OF NEVADA
COUNTY OF CLARK

The foregoing instrument was acknowledged before me
this ______ day of _________________, _______, by
______________________________, who provided
proper identification.

____
Notary Public

My commission expires: ________________