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

COORDINATION OF BENEFITS

Employee: ____

Do you and/or your dependents have health coverage other than through the Health Trust? Please check the correct line.

____ **NO**, I only have health coverage through the Health Trust.

____ **NO**, my dependents only have health coverage through the Health Trust.

If you mark "No" above for all family members, please stop here and sign and date below.

I certify that the information supplied above is true, correct, and complete. I will notify the Health Trust when my family members' medical, dental, or prescription plans change. I authorize the Health Trust to verify any information contained on this form.

____ ____________________

Signature ***Date***

____ **YES**, I have health coverage through another plan.

Please complete the information requested below, sign, and date.

This coverage is Active ___ Retired ___ or Medicare Part A and/or B ___

____ **YES**, my dependents have health coverage through another plan.

Please complete the information requested below, sign, and date.

This coverage is Active ___ Retired ___ or Medicare Part A and/or B ___

MEDICAL

Name & phone number of employer sponsoring this plan:

____

Name & phone number of insurance carrier:

____

Name of policyholder and date of birth:

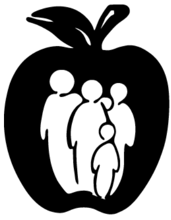
____

Individuals covered under this plan:

____

Effective Date of Coverage:

____



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DENTAL

Name & phone number of employer sponsoring this plan:

Name & phone number of insurance carrier:

Name of policyholder and date of birth:

Individuals covered under this plan:

Effective Date of Coverage:

PRESCRIPTION

Name & phone number of employer sponsoring this plan:

Name & phone number of insurance carrier:

Name of policyholder and date of birth:

Individuals covered under this plan:

Effective Date of Coverage:

If there is more than one insurance plan/carrier, please list all information on an additional form.

I certify that the information supplied above is true, correct, and complete. I will notify the Health Trust when my family members' medical, dental, or prescription plans change. I authorize the Health Trust to verify any information contained on this form.

Signature ***Date***