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

STUDENT STATUS VERIFICATION

Date: ____________________

Employee: _________________________________ Identification Number/SS#: _________________________________

Student's Name: _________________________________ Student's Social Security Number: ______________________

Name and Address of College, University, or Educational Institution:

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Is the above student considered full time? ______Yes ______No

Semester/Term:	Dates of Semester/Term:	Number of Credits:
________________	________________________	______________

____ ______________________

Signature of Registrar ***Date***

(OFFICIAL UNIVERSITY SEAL)

The Teachers Health Trust will accept this form, or a comparable form or letter, from the school or an authorized agent of the school as verification of school enrollment.

EMPLOYEE CERTIFICATION OF DEPENDENT ELIGIBILITY

I, ___________________________, certify that I am providing 50% or more of the support for my dependent who has met the Trust's Student Status requirements. I acknowledge that it is my responsibility to notify the Trust when I am no longer providing support for my dependent or when my dependent is no longer meets the Student Status requirements of the Trust.

____ ______________________

Signature ***Date***