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

Re: Domestic Partner Annual Verification

Dear Participant:

Teachers Health Trust records indicate that you currently have a Domestic Partner enrolled for coverage in the Diamond Plan (formerly the PPO Plus Plan) or Platinum Plan (formerly the PPO Plan).

The Trust requires annual verification of your domestic partner relationship. Please review the Domestic Partner policy to ensure that your domestic partner still qualifies as an eligible dependent. If so, you and your Domestic partner must complete the enclosed "Declaration of Domestic Partnership" form **and initial Stipulation "F"** on the bottom of the form indicating that you understand your premiums will be deducted on an "after tax basis." Your initials on Stipulation "F" acknowledge your understanding that you are not eligible for the Section 125 Premium-Only-Plan. (Additional information about the Premium-Only-Plan can be found on our website at www.teachershealthtrust.org).

In addition to the verification, the Trust requires you to submit copies of your birth certificate and your domestic partners birth certificate.

It is not necessary to have the "Declaration of Domestic Partnership" form notarized when submitting it for purposes of the annual verification.

If you do not submit the signed "Declaration of Domestic Partnership" form and both birth certificates by May 12, 2008, coverage for your Domestic Partner will be terminated effective May 31, 2008.

If you have any questions or require additional information, please contact the Service Department at 794-0272 or 800-432-5859 between 8:00 a.m. and 5:00 p.m., Monday through Thursday, and 9:00 a.m. and 4:30 p.m., Friday. You may also e-mail the Service Team at serviceteam@teachershealthtrust.org.

Sincerely,

Eligibility Department
Teachers Health Trust

Enclosure

Teachers Health Trust

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TEACHERS HEALTH TRUST
DECLARATION OF DOMESTIC PARTNERSHIP

I. Certification

We, ____, SSN/ID #______________________________,
Employee *(Last Name, First, M.I.)*

AND

____, SSN/ID #______________________________,
Domestic Partner *(Last Name, First, M.I.)*

certify that we are domestic partners in accordance with the following criteria and eligible for benefits coverage as domestic partners.

II. Domestic Partner Eligibility Criteria

"Domestic Partner Relationship" is defined as two adults (at least 18 years of age) of the same or opposite sex who have chosen to reside together and share a mutual obligation of support for the basic necessities of life.

Based on this definition, we declare and acknowledge that we meet all of the following criteria:

A. Maintain or share a primary residence.

B. Be jointly responsible to each other for basic living expenses; i.e., shelter, food, clothing (contributions need not be equal).

C. Are not currently married to another person.

D. Have not enrolled another domestic partner for Teachers Health Trust health coverage in the previous six-month period, unless such other person is deceased.

E. Are at least 18 years of age.

F. Are not blood relatives any closer than would prohibit legal marriage in the state of residence.

G. Are legally competent to consent to a contract.

H. Are financially interdependent by designation as a no less than 50% primary beneficiary for term life insurance provided through the Health Trust unless otherwise prohibited by court order.

III. Employee Acknowledgements

A. I agree to notify the Trust in writing within 31 days if there is a change in our status and will submit a Termination of Domestic Partnership form. I understand that failure to notify the Trust within 31 days of a change in our domestic partner relationship will result in forfeiture of all premiums paid and that coverage will be terminated the last day of the month in which the person no longer qualifies as my domestic partner. In addition, I acknowledge that I will be responsible for reimbursing the Trust for any claims which were paid on behalf of my domestic partner while my domestic partner was ineligible for coverage.

B. I understand that upon notification that the domestic partnership has ended, the coverage for the domestic partner will end the last day of the month in which the relationship terminates.

C. I understand that after such termination, a subsequent Declaration of Domestic Partnership cannot be filed until six months after the notification of the termination has been filed with the Trust, in writing.

D. I understand that I am responsible for the reimbursement of any expenses incurred as a result of any false or misleading statement contained in this Declaration of Domestic Partnership, including claims paid under any benefit plans in which I enroll my domestic partner.

E. I understand that the Health Trust is not providing legal advice and that I should consult an attorney and tax advisor regarding the possible legal and tax implications of filing this Declaration of Domestic Partnership.

F. I understand that premium payments for myself, my domestic partner, and any other eligible dependent must be made on an after-tax basis; **i.e., I may not pay for personal/domestic partner/dependent coverage through the IRS Section 125 plan. Initial**____________

G. I understand that this information will be kept confidential and has been requested solely for the purpose of determining eligibility and providing health benefits.

H. I understand that I may be asked to provide further information as required by the Trust to substantiate the domestic partner relationship and I agree to provide such additional information.

I. I understand that annual verification of my domestic partner relationship will be required.

IV. Declaration

A. **Employee**: I declare, under the penalty of perjury, that the foregoing is true and correct, executed this ______ day of _____________________, ______.

______________________________ ______________________________

Print Name *Signature*

______________________________ ______________________________

Address *City/State/Zip*

B. **Domestic Partner**: I declare, under the penalty of perjury, that the foregoing is true and correct, executed this ______ day of _____________________, ______.

______________________________ ______________________________

Print Name *Signature*

______________________________ ______________________________

Address *City/State/Zip*