



CT TEACHERS' RETIREMENT BOARD
765 ASYLUM AVENUE HARTFORD, CT 06105-2822
 Toll free 1-800-504-1102 X8411 or X 8432 (860) 241-8411 or (860) 241-8432 Fax (860) 622-2849
"An Affirmative Action/Equal Opportunity Employer"
www.ct.gov/trb

Health Insurance Change Form

This form is to be used by members, spouses or surviving spouses who are currently enrolled in the Teachers' Retirement Board Health Plan. This form is for adding the dental, vision and hearing coverage.

Only submit this health insurance change form if you are electing to add dental, vision and hearing coverage. Disregard this form if you are not making a change in your coverage.

- Due Date for those making changes is November 5, 2015.
- Your change will become effective January 1, 2016.
- Surviving spouses become ineligible upon remarriage.
- Spouses are ineligible for coverage upon divorce or legal separation.

| | Cost per person per month | Check Box |
|---------------------------------------------------------------------|---------------------------|--------------------------|
| Medicare Supplement with Prescriptions and Dental, Vision & Hearing | \$148 | <input type="checkbox"/> |

PLEASE PROVIDE THE FOLLOWING INFORMATION:

| | | | | |
|-----------------------------------------------|--|------------|-------------------------------------------------------------------------|---------------|
| Enrollee's Last Name First Name Initial | | | Home Phone | |
| Street Address City State Zip Code | | | Email Address | |
| | | | Gender <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | |
| Social Security # | | Medicare # | | Date of Birth |
| | | | | |
| Enrollee's Signature | | | Date | |
| | | | | |

IF YOU ARE THE SPOUSE OF A RETIRED/DECEASED TEACHER, PLEASE FURNISH THE FOLLOWING:

| | | |
|------------------------|-------------------------------------|---------------------|
| Retired Teacher's Name | Retired Teacher's Social Security # | Retiree's Signature |
| | | |