TEACHERS' RETIREMENT BOARD
165 Capitol Avenue
Hartford CT 06106-1673
1 (800) 504 - 1102

CERTIFICATION OF RESIDENCE FORM

THIS FORM IS FOR RETIRED MEMBERS WHO RESIDE IN A FACILITY WHICH REQUIRES THE RESIDENT TO OBTAIN PRESCRIPTION MEDICINE THROUGH THE FACILITY'S PHARMACY SO THAT THE RESIDENT CANNOT ORDER PRESCRIPTIONS VIA MAIL ORDER.

TO BE COMPLETED BY THE TRB HEALTH INSURANCE PLAN PARTICIPANT	
MEMBER NAME (PLEASE PRINT)	**SOCIAL SECURITY #**
MEMBER SIGNATURE	**DATE**

TO BE COMPLETED BY FACILITY REPRESENTATIVE	
FACILITY NAME (PLEASE PRINT)	
FACILITY ADDRESS	
FACILITY REPRESENTATIVE	**FACILITY REPRESENTATIVE TITLE**

The facility should retain a copy of this completed form to inform CTRB when the resident leaves the facility by checking the box below and returning the form to CTRB.

☐ The above named is no longer a resident of this facility.

FACILITY REPRESENTATIVE SIGNATURE	**DATE**