

Teamsters Joint Council No. 83 of Virginia

Trustees:

H. Joseph Ayers
W. Robert Davidson
John D. Farrish
Michael W. Hughes
Lindsay Marshall
William A. Nations

Health & Welfare Fund
8814 Fargo Road, Suite 200
Richmond, Virginia 23229-4673



Insured:

ID #:

Re:

Claims on your dependent cannot be processed until the following information is received.

1. Your social security number _____
2. Your employer's name _____
3. Your employer's address _____
4. Do you have other group insurance coverage? _____ Yes _____ No

*** If employed, please have employer complete the attached form. ***

5. If you answered "yes" to question 4, please advise the name of the insurance company

6. Have you remarried: _____ Yes _____ No

7. Spouse's name _____

8. Spouse's social security number _____

9. Spouse's employer _____

10. Address of spouse's employer _____

11. Does your spouse have any other group insurance? _____ Yes _____ No

12. If you answered "yes" to question 11, please advise the name of the insurance company

Date _____ Signature _____

**Teamsters Joint Council No. 83 of Virginia
Health and Welfare Fund
8814 Fargo Road, Suite 200 • Richmond, Virginia 23229**

Employer/company Name: _____

Employer/Company Address: _____

Attention: Personnel

Re: Your employee _____

SS # _____

Our insured, _____

Insured's SS# _____

We have been advised that you employ the above named individual. As our plan contains a coordination of benefits provision, the section below must be completed.

If the employee no longer has coverage, advise the type of coverage provided prior to the termination date.

Please complete the following:

1. Is the employee full time? _____ Part time? _____
Employee hire date: _____ Is group insurance provided? _____
2. Does your employee participate in the group plan? _____ Yes _____ No
If no, please advise if the coverage requires an employee contribution - _____
3. Is there an open enrollment period? _____ If so, when? _____
4. Coverage is - _____ Self only, _____ Self & dependents, _____ Dependents only
5. Effective date of insurance: _____ Termination date of insurance: _____
6. If terminated, was COBRA coverage elected? _____ Yes _____ No
COBRA effective date _____ COBRA termination date _____
7. Plan provides: _____ Basic Hospital/Medical _____ Major Medical _____ Dental _____
_____ Optical _____ Prescription drug (Copay \$ _____)
8. Coordination of benefits? _____ Yes _____ No
Birthday rule? _____ Yes _____ No Effective date _____
9. Name, address, phone # of insurance carrier _____

Plan policy or ID# (including BC/BS) _____
10. Your name (print or type) _____
Signed _____ Date _____
Position _____ Phone # _____