

Teamsters Joint Council No. 83 of Virginia Health & Welfare and Pension Funds



Administered by West End Administrators, Inc.
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COB YEARLY UPDATE

Once per year, this form is sent to all Participants with spouses to determine if your spouse has insurance available through his/her employer. This information is necessary so this Fund may coordinate its insurance payments with other insurance companies that provide benefits to your family. It is important to return this form before your current COB statement expires to avoid delay in the processing of your and/or your dependents' claims.

Is the Participant's spouse employed? Yes No

If yes, please sign and date below, then have your spouse's employer complete this form and return to this office using the contact information listed above or by email to documents@tjc83funds.net.

If no, please sign and date the form below and return it to this office using the contact information listed above or by email to documents@tjc83funds.net.

_____ _____ _____ _____
Participant's Printed Name Participant's Signature SSN or UID Date

Your Employee's Name: _____ Hire Date: _____
Your Employee's SSN: _____ Employer's Name: _____
Employer's Address: _____

Is group insurance coverage offered to this employee? Yes No
Is coverage free to this employee? Yes No
Would employee forfeit any other benefits by electing coverage? Yes No
Does employee participate? Yes No
Is there an open enrollment period? Yes No If so, when? _____

Does employee have any of the following benefits? Medical Dental Optical Prescription Drug
Effective date of coverage? _____ Termination Date of Coverage _____
Is coverage for self or self/dependent? _____
List dependents covered _____

Name of insurance carrier _____ Tel No. _____
Does carrier use the birthday rule or gender rule to determine liability? _____
Group Policy No. _____
Name of person completing this form (printed) _____
Signature of person completing this form _____
Position: _____ Tel No. _____ Date: _____