

Teamsters Joint Council No. 83 of Virginia

Health & Welfare and Pension Funds

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Dependent Form

The following information is needed on your dependent: Spouse Child/Stepchild/Grandchild/or other

Participant's Name _____ Participant's SSN or UID _____

Participant's Address _____

Dependent's name _____ Date of Birth _____

Relationship to you _____ SSN _____

Dependent's home address _____

This form must be accompanied by a copy of: Birth Certificate or proof of birth letter Marriage Certificate

If this dependent child is a stepchild, grandchild or the relationship is other than natural child, complete the following:

Does this dependent live with you in a normal parent-child relationship? Yes No

Is dependent entirely dependent on you? Yes No

Who claims this dependent for a tax exemption? _____

Are you responsible for all expenses incurred by this dependent? Yes No

Is this dependent legally adopted by you? Yes No (Legal documents must be provided supporting this statement.)

Are you legal guardian or have legal custody of this dependent? Yes No

If yes, provide legal documents supporting this statement.

Is anyone court ordered to provide insurance coverage for this dependent? Yes No

If yes, provide legal documents supporting this statement.

Is dependent employed? Yes No **If yes, have employer complete the attached form.**

If "yes", provide complete name and address of employer: _____

Is this dependent covered by other group insurance? Yes No *If "yes" provide the:*

Name of insurance company _____

Policy or certificate number _____

Address of insurance company _____

Full name of policyholder _____

I hereby certify that the above information is true and accurate.

Participant's Signature _____ Date _____