

Teamsters Joint Council No. 83 of Virginia
Health & Welfare and Pension Funds
8814 Fargo Road, Suite 200 • Richmond, VA 23229
1-804-282-3131 • 1-800-852-0806
Web Address: www.tjc83funds.org

This form will be returned to you as incomplete if you do not designate a beneficiary (Section 3) or you fail to sign Section 3 or 5.

SECTION 1 - PURPOSE

- NEW ENROLLEE
- ADD DEPENDENT/SPOUSE
 - Marriage
 - Birth/Adoption

EVENT DATE

- DELETE DEPENDENT/SPOUSE

Divorce - Date _____

Death - Date _____

Name of Dependent/Spouse _____

- OTHER _____

SECTION 2 - PERSONAL INFORMATION

_____ () _____ Single Married
SOCIAL SECURITY NUMBER AREA CODE HOME PHONE BIRTH DATE

EMPLOYEE _____ SEX _____
LAST NAME FIRST NAME MIDDLE INITIAL

ADDRESS _____ CITY STATE ZIP
STREET

EMAIL ADDRESS _____ HIRE DATE _____

ARE YOU CURRENTLY COVERED BY ANOTHER PLAN? YES NO

IF YES, DATE COVERAGE WILL TERMINATE _____

SECTION 3 - HEALTH & WELFARE BENEFICIARY (Recipient of Life Insurance Benefits, if applicable)

BENEFICIARY _____ RELATIONSHIP _____

BENEFICIARY SOCIAL SECURITY NUMBER _____

If you are not adding any dependents, please sign and date below.

X _____
SIGNATURE DATE

SECTION 4 - SPOUSE INFORMATION (To add a spouse, you must submit a marriage certificate.)

SPOUSE'S NAME _____ Date of Birth _____

Social Security Number _____

SPOUSE'S EMPLOYER: _____ SPOUSE IS NOT EMPLOYED

ADDRESS: _____

PHONE No. _____

SECTION 5 DEPENDENT INFORMATION

1. NAME _____ Relationship _____
Social Security Number _____ Date of Birth _____
Address (if different than Participant's) _____

Married Single If married, date of marriage _____

2. NAME _____ Relationship _____
Social Security Number _____ Date of Birth _____
Address (if different than Participant's) _____

Married Single If married, date of marriage _____

3. NAME _____ Relationship _____
Social Security Number _____ Date of Birth _____
Address (if different than Participant's) _____

Married Single If married, date of marriage _____

4. NAME _____ Relationship _____
Social Security Number _____ Date of Birth _____
Address (if different than Participant's) _____

Married Single If married, date of marriage _____

5. NAME _____ Relationship _____
Social Security Number _____ Date of Birth _____
Address (if different than Participant's) _____

Married Single If married, date of marriage _____

6. NAME _____ Relationship _____
Social Security Number _____ Date of Birth _____
Address (if different than Participant's) _____

Married Single If married, date of marriage _____

SECTION 5 (CONTINUED)

DOCUMENTATION/ELIGIBILITY REQUIREMENTS:

To Add	You must submit the following:	In addition, the dependents listed must:
a spouse	marriage certificate, dependent form and if your spouse is employed, an Employer Inquiry Form	1. Have lived with you over 50% of the year (time spent in school or on vacation is counted as living with you); 2. Not have provided over 50% of their own support; 3. Not be claimed on another individual's tax return. However, if you have a divorce decree or Qualified Medical Child Support Order (QMCSO) that requires you to provide health insurance coverage, coverage will be provided regardless of the answers to questions 1-3 above. Please submit a copy of either the divorce decree or QMCSO to the Fund Office by mail, email or fax.
a child born to you	dependent form, child's birth certificate identifying you as the parent or legal paternity documentation	
an adopted child	dependent form, child's birth certificate & adoption papers	
a stepchild	dependent form, child's birth certificate & your marriage certificate	
a child for which you have legal custody & lives with you in a normal parent child relationship	dependent form, child's birth certificate, a copy of custody papers and a statement that neither parent lives with you	
an unmarried, dependent child who is a full time student and between the age of 19 and 22	student verification form (Updated student verification forms are required at least twice a year)	

Certification: I certify that all dependents listed meet the requirements of items 1-3 or I am required to provide coverage as specified in a Qualified Medical Child Support Order or divorce decree.

X

Signature

Date

For more information, please contact Marcella Wright, Operations Specialist at 804-282-3131 or toll free at 800-852-0806. You may also email us at yourfund@tjc83funds.net.

SECTION 6 EMPLOYER AND LOCAL UNION NUMBER

EMPLOYER _____
LOCAL UNION No. _____

This section to be completed by the Fund Office.

Company Code: _____
Plan: _____
Effective Date: _____
UID _____