

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



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INSURANCE VERIFICATION FORM

This form must be completed by employer.

Employer Name and Address: _____

Your Employee's Name: _____ Your Employee's SSN: _____

Teamsters Fund Participant's Name: _____

****PLEASE COMPLETE THE SECTIONS BELOW THAT APPLY TO YOUR EMPLOYEE****

Is group insurance coverage offered to employees? Yes No

Does coverage require an employee contribution? Yes No

Does employee participate? Yes No

Would employee forfeit any other benefits by electing coverage? Yes No

Is there an open enrollment period? Yes No If yes, when? _____

Does employee have any of the following benefits?

Medical Dental Vision Prescription Drugs

Effective Date of Coverage: _____ Termination Date of Coverage: _____

Coverage is for: Self Only Self and Dependent

If applicable, list dependents covered: _____

Name of insurance carrier _____ Phone No. _____

Does carrier use the birthday or gender rule to determine primary liability? _____

Group Policy No. _____

Name of person completing this form (printed): _____

Signature of person completing this form _____

Title: _____ Phone number: _____ Date: _____