

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



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

Dear Participant:

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) now mandates the reporting of certain information for individuals who have coverage under group health plans (GHP). Because the Fund is considered a group health plan, we are required by the MMSEA to obtain the social security number of all eligible dependents on your policy. This information must be reported to the Centers for Medicare & Medicaid Services.

This information will be used to determine if someone filing a claim with Medicare (currently or in the future) is already covered by another insurance carrier. For some individuals who have coverage through both Medicare and a GHP, Medicare should be the secondary carrier. Knowing prior to claim processing whether or not Medicare should be primary or secondary may reduce the number of overpayments by Medicare.

Because of the importance of this information, we are requiring that you return this form immediately. **Your coverage will be terminated if this information is not received.** If your coverage is terminated, it will be reinstated upon receipt of your dependents' social security numbers and any claims that were denied will be reopened.

Please complete and return the following form in order to satisfy the requirement for this information. It may be returned by mail, fax, or email to documents@tjc83funds.net. You may also visit our website, www.tjc83funds.org to download the form. Do not hesitate to call if you have any questions. Thank you in advance for your help in this matter.

Sincerely,

A handwritten signature in cursive script that reads "Kellie M. Rhodes".

Kellie M. Rhodes
Vice President
West End Administrators
Administrator for Teamsters Joint Council No. 83 of Virginia Health and Welfare Fund

West End Administrators
8814 Fargo Road · Suite 200 · Richmond, VA 23229
Telephone (804) 282-3131 · 1-800-852-0806 · Fax (804) 288-3530

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Dependent Social Security Number Request

I certify that the listing of Social Security Numbers below is complete and accurate.

Dependent's Name

Dependent's Social Security Number

Member's Printed Name

Member's ID Number or SSN

Member's Signature

Date