Teamsters Joint Council No. 83 of Virginia Health and Welfare Fund
8814 Fargo Road, Suite 200 • Richmond, VA 23229
(804) 282-3131 • Fax (804) 288-3530

# Pre-existing Condition Form

Insured's Name ______________________________ ID# ______________

Employer ______________________________ Local # ______________

No claims will be considered on you or your dependents until this form is received by the Fund Office. Any condition for which you or your dependents are treated within the 90 days immediately prior to your effective date of coverage will not be covered until your insurance or your dependent's insurance has been in effect for 6 months.

**1.** Have you or any of your dependents received medical advice and/or treatment for any of the following conditions in the past six (6) months? If yes, list the dependent's name and physician's name.

| Condition | Circle One | Last Treatment Date Prior to Effective Date of Benefits | Self/Dependent | Physician | Physician's Phone # |
|---|---|---|---|---|---|
| High blood pressure | Yes No | | | | |
| Diabetes | Yes No | | | | |
| Allergies | Yes No | | | | |
| Heart condition | Yes No | | | | |
| Arthritis | Yes No | | | | |
| Back problems | Yes No | | | | |
| Cancer | Yes No | | | | |
| Respiratory conditions | Yes No | | | | |
| Seizures | Yes No | | | | |
| Glaucoma | Yes No | | | | |
| Cataracts | Yes No | | | | |
| Circulation/Stroke | Yes No | | | | |
| Multiple Sclerosis | Yes No | | | | |
| Cystic Fibrosis | Yes No | | | | |
| HIV (human Immunodeficiency Virus) | Yes No | | | | |
| AIDS (Acquired Immune Deficiency | Yes No | | | | |
| Other (If yes, see below) | Yes No | | | | |

**2.** List any other conditions for which you or your dependents have received medical advice and/or treatment in the past six (6) months (use back of form if needed).

| Self/Dependent | Condition | Last Treatment Date Prior to Effective Date of Benefits | Physician | Physician's Phone # |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**3.** Have you or any of your dependents been advised by a health care provider that hospitalization or a surgical procedure is necessary in the future? YES NO If yes, which dependent? List the condition or procedure.

Information given is subject to verification from attending physician(s). Any false statements may result in you being liable for all claims paid by the Fund. False or misleading information may result in your loss of coverage with the Fund.

I authorize the release of any medical information necessary for pre-existing purposes.

Employee's Signature ______________________________ Date ______________