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

Administered by West End Administrators
8814 Fargo Road · Suite 200 · Richmond, VA 23229
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QUALIFYING CHILD COB YEARLY UPDATE

Once per year, this form is sent to all qualifying children age 18 and older to determine if you have access to employment based health insurance. It is important to return this form before your current COB statement expires to avoid delay in the processing of your claims.

Are you employed? **Yes** **No**

If yes, please sign and date below, then have your employer complete this form and return to this office using the contact information listed above or by email to documents@tjc83funds.net.

If no, please sign and date the form below and return it to this office using the contact information listed above or by email to documents@tjc83funds.net.

____________________ Dependent's Printed Name

____________________ Dependent's Signature

__________ Date

____________________ Participant's Name

____________________ Participant's SSN or UID

If your mailing address is different than the address used for this correspondence, please update your contact information.

____________________ Mailing Address

__________ Phone Number

____________________ City, State, Zip

Your Employee's Name: ____________________ Hire Date: __________

Your Employee's SSN: __________ Employer's Name: ____________________

Employer's Address: ______________________________

Is group insurance coverage offered to this employee? Yes No
Is there an open enrollment period? Yes No If so, when?____________________

Effective date of coverage? __________ Termination Date of Coverage __________

Name of insurance carrier____________________ Tel No.__________

Group Policy No. ______________________________

Name of person completing this form (printed) ____________________

Signature of person completing this form ____________________

Position: ____________________ Tel No. __________ Date: __________