

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



Administered by West End Administrators, Inc.
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Retiree Employment Verification Form (This form is to be filled out by the retiree's employer)

ATTN: HUMAN RESOURCES/PERSONNEL

Employer Name and Address: _____

Your Employee's Name: _____ SSN: _____

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

Employee Hire Date: _____ Termination Date: _____
Employment Status: Full time Part time
Is Group Insurance available? Yes No
Does employee participate? Yes No
Available coverage is (or would be) for: Self Only _____ Employee Cost or Self and Dependent(s) _____ Employee Cost
Is there an open enrollment period? Yes No If so, when? _____

*****PLEASE FILL OUT THIS SECTION EVEN IF EMPLOYEE HAS TERMINATED*****

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

Coverage:

Basic/Major Medical	Yes	No
Dental	Yes	No
Optical	Yes	No
Prescription Drug Copay	Yes	No
Prescription Drug Covered by Major Medical	Yes	No

*****COORDINATION OF BENEFITS PROVISION*****

Does carrier use the birthday rule or gender rule for determining liability? _____
Name, address and telephone number of Insurance Carrier/Carriers:

_____ Group Policy No. _____
_____ Group Policy No. _____
_____ Group Policy No. _____

Name of person completing this form (printed) _____
Signature of person completing this form _____ Date _____
Position _____ Phone No. _____