

TEAMSTERS JOINT COUNCIL NO. 83 OF VIRGINIA
HEALTH AND WELFARE FUND
8814 FARGO ROAD, SUITE 200 · RICHMOND, VIRGINIA 23229
TELEPHONE 804-282-3131 · FAX 804-288-3530

RETIREE INSURANCE 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: _____

Your Employee's Social Security Number: _____

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

Employee Hire Date: _____ Termination Date: _____

Is Employee: Full time / Part time Is Group Insurance Available? Yes No

If Group Insurance is available, is there a payroll deduction for this group coverage? Yes No

Does Employee Participate? Yes No

Available Coverage is (or would be) for: Self only _____ or Self and Dependent(s) _____
Employee Cost *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 PRESCRIPTION DRUG COPAY Yes No

DENTAL Yes No PRESCRIPTION DRUG COVERED

OPTICAL Yes No 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: _____

Position: _____ Phone number: _____

Date: _____

****THIS FORM MUST BE FILLED OUT BY EMPLOYER****