

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

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## INSURANCE VERIFICATION FORM

Once per year, this form is sent to all Participants with spouses to determine if your spouse has insurance available through his/her employer. This information is necessary so this Fund may coordinate its insurance payments with other insurance companies that provide benefits to your family. It is important to return this form before your current COB statement expires to avoid delay in the processing of your and/or your dependents' claims.

**Is the Participant's spouse employed?**      Yes      No

**If yes, please have your spouse's employer complete this form and return to this office using the contact information listed above or by email to [documents@tjc83funds.net](mailto: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](mailto:documents@tjc83funds.net).**

\_\_\_\_\_ Participant's Name      \_\_\_\_\_ Participant's Signature      \_\_\_\_\_ SSN or UID      \_\_\_\_\_ Date

Your Employee's Name: \_\_\_\_\_ Hire Date: \_\_\_\_\_  
Your Employee's SSN: \_\_\_\_\_ Employer's Name: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_

Is group insurance coverage offered to employees?      Yes      No  
Does coverage require employee contribution?      Yes      No  
Does employee participate?      Yes      No  
Would employee forfeit any other benefits by electing coverage?      Yes      No  
Is there an open enrollment period?      Yes      No      If so, when? \_\_\_\_\_

Does employee have any of the following benefits?      Medical      Dental      Optical      Prescription Drug  
Effective date of coverage? \_\_\_\_\_ Termination Date of Coverage \_\_\_\_\_  
Is coverage for self or self/dependent? \_\_\_\_\_  
List dependents covered \_\_\_\_\_

Name of insurance carrier \_\_\_\_\_ Tel No. \_\_\_\_\_  
Does carrier use the birthday rule or gender rule to determine liability? \_\_\_\_\_  
Group Policy No. \_\_\_\_\_  
Name of person completing this form (printed) \_\_\_\_\_  
Signature of person completing this form \_\_\_\_\_  
Position: \_\_\_\_\_ Tel No. \_\_\_\_\_ Date: \_\_\_\_\_