

**TEAMSTERS JOINT COUNCIL NO. 83 OF VIRGINIA
HEALTH AND WELFARE FUND**

8814 Fargo Road, Suite 200 • Richmond, Virginia 23229
Telephone 282-3131 (local) or 1-800-852-0806 (out of the area)

Participant's Name: _____

Participant's ID # _____

CLAIMS ON YOUR DEPENDENTS CANNOT BE PROCESSED UNTIL THE FOLLOWING INFORMATION IS RECEIVED.

Current Marital Status Single Married Separated Divorced

Spouse's Name _____ Spouse's SS # _____

Spouse's Address _____

Spouse's Employer: _____

Employer's Address: _____

Is spouse covered by other group insurance? _____ If yes, policy # _____

Insurance company's name and address: _____

Spouse's birth date _____ Marriage date _____
(Send copy of marriage certificate)

Do you have children/stepchildren/grandchildren/other that reside with you? If yes, complete the following:

Child's full name and address	Relationship to you	Who has custody?	Who claims for taxes
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is anyone required by court order to provide insurance for any of the children listed?

Yes _____ No _____

If yes, please provide the following:

Name of child	Name and address of person required to provide insurance
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

The following information is also required to process claims on your dependent(s).

- Full name and address of your ex-spouse: _____

- A copy of your divorce decree from the above ex-spouse
- A copy of the birth certificate for: _____

All of the information requested is confidential. It will be used solely for determining your dependent's eligibility for health coverage under your Fund benefits.

I hereby certify that the information given on this form is true and accurate.

Signed _____

Dated _____