

**Teamsters Joint Council No. 83 of Virginia  
Health and Welfare Fund  
8814 Fargo Road, Suite 200 • Richmond, Virginia 23229  
Telephone (804) 282-3131 • Toll Free 1-800-852-0806**

**RETIREMENT HEALTH BENEFIT GROUP INSURANCE INQUIRY**

1. Are you employed? \_\_\_ Yes \_\_\_ No Employer's name and full address:  
\_\_\_\_\_  
\_\_\_\_\_
  
2. Are you covered by other group health coverage? \_\_\_ Yes \_\_\_ No  
Carrier's Name, full address and contract/policy number: \_\_\_\_\_  
\_\_\_\_\_
  
3. Are you married? \_\_\_ Yes \_\_\_ No Spouse's name \_\_\_\_\_  
Spouse's SS # \_\_\_\_\_ Spouse's date of birth \_\_\_\_\_
  
4. Is your spouse employed? \_\_\_ Yes \_\_\_ No Employer's name and full address:  
\_\_\_\_\_  
\_\_\_\_\_
  
5. Is your spouse covered by other group health insurance? \_\_\_ Yes \_\_\_ No  
Carrier's Name, full address and contract/policy number: \_\_\_\_\_  
\_\_\_\_\_
  
6. Do you have dependent children who had health coverage under this plan when you retired?  
\_\_\_ Yes \_\_\_ No Complete the following for each dependent (use back of form if needed)  

<u>Dependent child's name</u>	<u>Soc. Sec. No.</u>	<u>Birth date</u>
_____	_____	_____
_____	_____	_____
  
7. Are any of the listed dependent children employed? \_\_\_ Yes \_\_\_ No If yes, list the dependent's name and the dependent's employer's name and address:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
8. Are any of the listed dependent children covered by other group health coverage?  
\_\_\_ Yes \_\_\_ No Carrier name, full address and contract/policy number for each dependent:  
\_\_\_\_\_  
\_\_\_\_\_
  
9. Are you covered by Medicare? \_\_\_ Yes \_\_\_ No If yes, submit a copy of the Medicare card unless previously submitted.
10. Does Medicare cover **your spouse** or any of your dependent children? \_\_\_ **Yes** \_\_\_ **No** \_\_\_ **N/A**  
If yes, submit a copy of the Medicare card unless previously submitted.
11. Are **you, your spouse** or dependent children receiving Social Security Disability Benefits? \_\_\_ Yes \_\_\_ No  
If yes, submit a copy of the Disability Award letter.

I hereby verify that all of the above information is accurate and true.

Signed \_\_\_\_\_ Dated \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_