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

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INSURANCE VERIFICATION FORM

This form must be completed by the employer.

Employer Name and Address: ____

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Your Employee's Name: ______________________________ Your Employee's SSN: ____________

Teamsters Fund Participant's Name: ____

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

Is group insurance offered to this employee? Yes No

Does coverage require an 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 yes, when? ____________________

Does employee have any of the following benefits?

Medical Dental Vision Prescription Drugs

Effective Date of Coverage: ________________ Termination Date of Coverage: ________________

Coverage is for: Self Only Self and Dependent

If applicable, list dependents covered: ____

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Name of insurance carrier__________________________________ Phone No.______________

Does carrier use the birthday or gender rule to determine primary liability? ____________________

Group Policy No.____

Name of person completing this form (printed): ____________________________________

Signature of person completing this form____

Title: ________________________ **Phone number:**______________ **Date:** ______________