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

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INSURANCE BENEFITS ENROLLMENT FORM

Before You Begin: Complete all applicable sections, print clearly, attach required documentation, and sign the form before submitting. Unsigned forms will be returned as incomplete.

PARTICIPANT INFORMATION (Please print)

Last Name	First Name	Middle Name	Gender ☐ Male ☐ Female

Home Address	City	State	Zip Code	Marital Status ☐ Single ☐ Married

SSN	Phone No. ( )	Date of Birth Month	Day	Year	Local Union No.	Date of Hire	Employer

Email Address

DEPENDENT INFORMATION — Complete only if adding a spouse or dependent. Provide the following documentation for eligibility verification

- Marriage Certificate (for spouse)
- Birth Certificate for all added dependents
- Any court documentation pertaining to a minor's custody or benefit coverage for any added dependent
  - Divorce Decree
  - Custody Agreement
  - Adoption Paperwork

IMPORTANT: A spouse or dependent will not be enrolled OR granted eligibility until all required documentation is received and verified by the Fund Office

Last Name	First Name	M.I.	SSN	Date of Birth Month	Day	Year	Relationship	Is Dependent Employed?	Dependent Address if Different from Participant
Spouse								☐ Yes ☐ No	
Dependent								☐ Yes ☐ No	
Dependent								☐ Yes ☐ No	
Dependent								☐ Yes ☐ No	
Dependent								☐ Yes ☐ No	

OTHER COVERAGE INFORMATION — Complete only if you or any covered dependent has other coverage.

Last Name	First Name	Employer Name	If yes, Carrier Name & Policy No.	Carrier Phone No.

BENEFICIARY INFORMATION — Required: You must specify who should receive your Life Insurance benefit.

Name of Beneficiary	DOB	Address of Beneficiary	Relationship	% of Benefit (Total must = 100%)

CERTIFICATION AND SIGNATURE: I certify that the information provided on this Enrollment Form is true, complete, and accurate to the best of my knowledge.I understand that eligibility for benefits is governed by the terms of the applicable Plan documents and that I am responsible for notifying the Fund Office of changes that may affect me or my dependents' eligibility or coverage.

Participant Signature: _____ Date: _____

Privacy Notice: Please do not send original documents. Copies are sufficient for review. All information submitted will be used solely for Eligibility verification and plan administration purposes and will be handled in accordance with applicable privacy and confidentiality requirements.

For Fund Use Only

Received Date: _____ *Eff. Date:* _____
Company Code: _____ *Plan:* _____
Processed By: _____ *Date:* _____
Verified By: _____
Documentation Complete ☐*Yes* ☐*No*