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

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COB YEARLY UPDATE

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 sign and date below, then 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.

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.

_____ _____ _____ _____
Participant's Printed Name | Participant's Signature | SSN or UID | Date

_____ _____
Participant's Email Address | Participant's Phone Number

Your Employee's Name: _____ Hire Date: _____

Your Employee's SSN: _____ Employer's Name: _____

Employer's Address: _____

Is group insurance coverage offered to this employee? ☐ Yes ☐ No

Is coverage free to this employee? ☐ Yes ☐ No

Would employee forfeit any other benefits by electing coverage? ☐ Yes ☐ No

Does employee participate? ☐ 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: _____