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

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COB YEARLY UPDATE

This form is sent once per year to all Participants with spouses to determine if the spouse has insurance available through his/her employer. This information is used to coordinate payments with other insurance companies that provide benefits to your family. Please return this form before your current COB statement expires to avoid delay in processing claims.

Is the Participant's spouse employed?

☐ Yes - If yes, sign and date below, then have your spouse's employer complete and return to the Fund office.

☐ No - If no, please sign and date below and return to the Fund office.

This section must be completed by Participant.

Your Name	Your SSN
Your Mailing Address	City, St Zip
Your Email Address	Your Phone No.
Your Signature	Date

This section must be completed by spouse's employer if applicable.

Your Employee's Name	Your Employee's SSN	Employee's Hire Date
Employer's Name	Employer's Mailing Address	
Is group insurance coverage offered to this employee? ☐ 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 so, when?	
Is coverage free to this employee? ☐ Yes ☐ No	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? ☐ Self ☐ Self/dependent	List dependents covered	
Name of Insurance Carrier	Phone No.	
Does carrier use the birthday rule or gender rule to determine liability?	Group Policy No.	
Name of person competing this form (printed)	Signature of person completing this form	
Title	Phone No.	Date