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: _____

_____

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: _____

_____

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:** _____