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

www.tjc83funds.org
8814 Fargo Road · Suite 200 · Richmond, VA 23229
Phone (804) 282-3131 · 800-852-0806 · Fax (804) 288-3530
Email: documents@tjc83funds.net

QUALIFYING CHILD COB YEARLY UPDATE

This form is sent once per year to all qualifying children age 18 and older to determine if insurance is available through the child's employer. Please return this form before your current COB statement expires to avoid delay in processing claims.

Are you employed?

☐ Yes - If yes, complete Section 1, then have your employer complete Section 2 and return form to the Fund office.

☐ No - If no, complete Section 1 and return form to the Fund office.

Section 1 - This section must be completed by the Qualifying Child.

Your Printed Name	Participant's SSN or UID
Your Mailing Address	City, St Zip
Your Email Address	Your Phone No.
Your Signature	Date

Section 2 - This section must be completed by the Qualifying Child's employer if applicable.

Your Employee's Name	Your Employee's SSN	
Employer's Name	Employer's Mailing Address	
Is coverage free to this employee? ☐ Yes ☐ No	Would employee forfeit any other benefits by electing coverage? ☐ Yes ☐ No	
Does employee participate in group insurance coverage? ☐ Yes ☐ No	Does employee have any of the following benefits? ☐ Medical ☐ Dental ☐ Optical ☐ Prescription Drug	
Date of Hire	Effective Date of Coverage	Termination Date of Coverage
Name of Insurance Carrier	Phone 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	
Title	Phone No.	Date