

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, sign and date below, then have your 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 the Qualifying Child.		
Your Name	Participant's SSN or UID	
Your Mailing Address	City, St Zip	
Your Email Address	Your Phone No.	
Your Signature	Date	
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	
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