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

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QUALIFYING CHILD COB YEARLY UPDATE

Once per year, this form is sent to all qualifying children age 18 and older to determine if you have access to employment based health insurance. It is important to return this form before your current COB statement expires to avoid delay in the processing of your claims.

Are you employed? ☐ **Yes** ☐ **No**

If yes, please sign and date below, then have your 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.

_____ _____ _____
Dependent's Printed Name | Dependent's Signature | Date

_____ _____
Participant's Name | Participant's SSN or UID

If your mailing address is different than the address used for this correspondence, please update your contact information.

_____ _____
Mailing Address | Phone Number

_____
City, State, Zip

Your Employee's Name: _____ Hire Date: _____

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

Employer's 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

Is there an open enrollment period? ☐ Yes ☐ No If so, when?_____

Effective date of coverage? _____ Termination Date of Coverage _____

Name of insurance carrier_____ Tel No._____

Group Policy No. _____

Name of person completing this form (printed) _____

Signature of person completing this form _____

Position: _____ Tel No. _____ Date: _____