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

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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

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 competing this form (printed)	Signature of person completing this form

Title	Phone No.	Date