

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



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Retirement Health Benefit Group Insurance Inquiry

1. Are you employed? Yes No Employer's name and full address:

2. Are you covered by other group health coverage? Yes No
Carrier's Name, full address and contract/policy number: _____

3. Are you married? Yes No Spouse's name _____
Spouse's SSN _____ Spouse's date of birth _____

4. Is your spouse employed? Yes No Employer's name and full address: _____

5. Is your spouse covered by other group health insurance? Yes No
Carrier's Name, full address and contract/policy number: _____

6. Do you have dependent children who had health coverage under this plan when you retired? Yes No
Complete the following for each dependent (use back of form if needed)

<u>Dependent child's name</u>	<u>SSN</u>	<u>Date of Birth</u>
_____	_____	_____
_____	_____	_____

7. Are any of the listed dependent children employed? Yes No If yes, list the dependent's name
and the dependent's employer's name and address:

8. Are any of the listed dependent children covered by other group health coverage? Yes No
Carrier name, full address and contract/policy number for each dependent:

9. Are you covered by Medicare? Yes No If yes, submit a copy of the Medicare card unless previously
submitted.

10. Does Medicare cover **your spouse** or any of your dependent children? Yes No N/A
If yes, submit a copy of the Medicare card unless previously submitted.

11. Are **you, your spouse** or dependent children receiving Social Security Disability Benefits? Yes No
If yes, submit a copy of the Disability Award letter.

I hereby verify that all of the above information is accurate and true.

Participant's Signature _____ Date _____

Participant's Printed Name _____ UID _____ Birth Date _____