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)

Dependent child's name	SSN	Date of Birth

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 _____