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

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ENROLLMENT FORM

Please note: This form will be returned to you as incomplete if you do not sign it.

PARTICIPANT INFORMATION (Please print all information.)

Last Name	First Name	Middle Name	Gender
			☐ Male ☐ Female

Home Address	City	State	Zip	Marital Status
				☐ Single ☐ Married

SSN	Phone No.	Date of Birth (Month / Day / Year)	Local Union No.	Date of Hire	Employer
				Email Address	

☐ Check this box if you would like to opt out of vision and dental coverage. There will be no reduction in your premiums by doing so.

DEPENDENT INFORMATION (For spouse, submit copy of marriage certificate. For <u>all</u> dependent child, submit copy of birth certificate. For an adopted child, also submit adoption papers. For a stepchild, also submit copy of your marriage certificate. For a child for which you have legal custody, also submit custody papers). If more space is needed, please attach a separate sheet with additional dependent information.

Last Name	First Name	Middle Initial	SSN	Date of Birth (Month)	(Day)	(Year)	Relationship	Is Dependent Employed?	Dependent Address if Different from Participant
Spouse								☐ Yes ☐ No	
Dependent								☐ Yes ☐ No	
Dependent								☐ Yes ☐ No	
Dependent								☐ Yes ☐ No	
Dependent								☐ Yes ☐ No	
Dependent								☐ Yes ☐ No	

OTHER COVERAGE INFORMATION (If you or any of your covered dependents have other coverage, please complete this section.)

Last Name	First Name	Employer Name	If yes, Carrier Name & Policy No.	Carrier Phone No.

BENEFICIARY INFORMATION (You <u>must</u> specify whom you would like to receive your Life Insurance Benefits.)

Name of Beneficiary	Address of Beneficiary	Relationship	Type or Percentage

I hereby certify that the information provided on this Enrollment Form is accurate.

Participant Signature _____ **Date** _____

For Fund Use Only
Company Code _____
Plan _____
Effective Date _____
UID _____