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

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Retirement Health Benefit Group Insurance Inquiry

Participant's Name		Participant's UID or SSN	Participant's date of birth
Are you employed? ☐ Yes ☐ No		Employer's name	
Employer's full address			
Are you covered by other group health coverage? ☐ Yes ☐ No		Carrier's name and policy number	
Carrier's full address			
Are you married? ☐ Yes ☐ No		Spouse's name	
Spouse's SSN		Spouse's date of birth	
Is your spouse employed? ☐ Yes ☐ No		Spouse's employer's name	
Spouse's employer's full address			
Is your spouse covered by other group health insurance? ☐ Yes ☐ No		Carrier's name and policy number	
Carrier's full address			
Are you covered by Medicare?	Is your spouse covered by Medicare?	Are you or your spouse receiving Social Security Disability Benefits?	****If you or your spouse are covered by Medicare of Social Security Disability benefits, please submit a copy of the Medicare card or Disability Award letter.*
Participant's Telephone Number		Participant's Full Address	
Participant's Signature			Date