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

www.tjc83funds.org
8814 Fargo Road · Suite 200 · Richmond, VA 23229
Phone (804) 282-3131 · 800-852-0806 · Fax (804) 288-3530
Email: documents@tjc83funds.net

GROUP LIFE INSURANCE CLAIM FORM

Instructions for Furnishing Proof of Death

1. Beneficiary or other claimant should complete Part I. Attach certified copy of deceased's Death Certificate and return to the Fund office for completion of Part II.

2. If any beneficiary (other than a contingent beneficiary) died before the Insured, a copy of the Certificate of Death of such beneficiary must be attached hereto. In such case, claim should be made by the other beneficiaries, or if there be none, by the duly appointed representative of the deceased's estate.

3. If claim is made on behalf of the estate of the deceased, a certified copy of the Letters of Administration must be attached hereto.

4. If any beneficiary is a minor or legally incompetent, a certified copy of the appointment of a guardian must be attached hereto.

Part I- Statement of Beneficiary or Other Claimant

1. Full name of deceased _____

2. Date of birth of deceased _____ Your date of birth _____

3. Your relationship to the deceased _____Your telephone no._____

4. Your address

_____
Street City or Town State ZIP Code

5. If you are not the named beneficiary, in what capacity do you make this claim?

_____

6. Your (Claimant's) Taxpayer Identification Number

Social Security Number_____

OR

Employer Identification Number _____

For exempt payees write "Exempt" here _____

CERTIFICATION — Under penalty of perjury, I certify that:

(a) The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me); and

(b) I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failing to report all interest and dividends, or the IRS has notified me that I am no longer subject to backup withholding.

Signature of Claimant	Date	Relationship To Insured

Authorization to Disclose Personal Information

To physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations, insurers, employers, consumer reporting agencies and all other providers of medical or dental services.

I authorize you to release to representatives of Teamsters Joint Council No. 83 of Virginia Health & Welfare Funds, personal information about the insured person including: medical history, mental and physical condition, prescription drug records, alcohol or drug use, financial and occupational information in order to evaluate my claim for benefits.

If the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the information may be redisclosed without the protection of the federal privacy regulations.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my claim for benefits may not be paid.

This authorization will expire 24 months after the date signed. I may revoke this authorization at any time by written notice sent to The Fund Office at the address shown above. Any revocation of this authorization will not affect any use or disclosure of Personal Information that occurred prior to the receipt of my revocation.

I understand that I am entitled to receive a copy of this authorization and that a copy is as valid as the original.

Name(s) used for medical records (if different than the name below):

_____

Printed Name of Insured Person	Printed Name of Authorized Person	Signature of Authorized Person

Relationship to Insured	Date