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

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Retiree Employment Verification Form

(*This form is to be filled out by the retiree's employer*)

ATTN: HUMAN RESOURCES/PERSONNEL

Employer Name and Address: _____

_____

_____

Your Employee's Name: _____ SSN: _____

*****PLEASE COMPLETE THE SECTIONS BELOW THAT APPLY TO YOUR EMPLOYEE*****

Employee Hire Date: _____ Termination Date: _____

Employment Status: ☐ Full time ☐ Part time

Is Group Insurance available? ☐ Yes ☐ No

Does employee participate? ☐ Yes ☐ No

Available coverage is (or would be) for: ☐ Self Only _____ (Employee Cost) ☐ or Self and Dependent(s) _____ (Employee Cost)

Is there an open enrollment period? ☐ Yes ☐ No If so, when? _____

*****PLEASE FILL OUT THIS SECTION EVEN IF EMPLOYEE HAS TERMINATED*****

Effective Date of Coverage: _____ Termination Date of Coverage: _____

COBRA Effective Date: _____ COBRA Termination Date: _____

Coverage:

☐ Basic/Major Medical	☐ Yes	☐ No
☐ Dental	☐ Yes	☐ No
☐ Optical	☐ Yes	☐ No
☐ Prescription Drug Copay	☐ Yes	☐ No
☐ Prescription Drug Covered by Major Medical	☐ Yes	☐ No

*****COORDINATION OF BENEFITS PROVISION*****

Does carrier use the birthday rule or gender rule for determining liability? _____

Name, address and telephone number of Insurance Carrier/Carriers:

_____ Group Policy No. _____

_____ Group Policy No. _____

_____ Group Policy No. _____

Name of person completing this form (printed) _____

Signature of person completing this form _____ Date _____

Position _____ Phone No.