Teamsters Health and Welfare Fund
of Philadelphia and Vicinity

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IMMEDIATE ACTION REQUIRED!

Dear Member:

Our office is in the process of updating our records so as to avoid any interruption in the processing of your claims.

As you are aware, your Plan of Benefits contains a "Coordination of Benefits" provision. This means that if your spouse is scheduled to work 32 or more hours per week and is offered medical benefits through his/her employer, he/she **MUST** enroll in that company's plan unless they are required to pay 100% of the premium.

In the event that your spouse must pay 100% of the premium or if he/she is not offered coverage, we will need a letter from his/her employer stating that fact.

We ask that you complete the reverse side of this form and return it to our office as soon as possible.

In the event that we do not receive a properly completed form from you, we will have no alternative but to deny your spouse's claims until the required information is received by the Fund office.

Sincerely,

William J. Einhorn for the Board of Trustees
Administrator

DECLARATION OF SPOUSE HEALTH COVERAGE

(To avoid any interruption in the processing of your claims, please complete and return this form to the Fund office)

MEMBER INFORMATION			
SOCIAL SECURITY #	NAME (LAST PLUS SUFFIX, FIRST, MI)	DATE OF BIRTH	PHONE #

SPOUSE'S INFORMATION			
SOCIAL SECURITY #	NAME (LAST PLUS SUFFIX, FIRST, MI)	DATE OF BIRTH	PHONE #

Does your spouse have other insurance coverage?	YES ☐	NO ☐

My spouse is (check one):

☐ employed full-time **(full-time is defined as scheduled to work 32 or more hrs/week, complete the remainder of this form))**

☐ not currently employed **(skip to the signature lines at the bottom and return the form to the Fund office)**

☐ employed part-time (number of hours regularly scheduled each week _____)

(if scheduled less than 32 hours per week, please sign on the signature lines and return to the Fund office)

☐ self employed

My spouse is employed by:

Employer's Name: _____

Employer's Address:_____

_____

_____

Employer's Phone #:_____

Human Resource Contact Name: _____

Human Resource Phone #: _____

SPOUSE'S MEDICAL COVERAGE			
GROUP #	MEMBER ID	CARRIER NAME	
CARRIER ADDRESS	CARRIER PHONE #	COVERAGE EFFECTIVE DATE	
What type of coverage is this policy?	SINGLE ☐	FAMILY ☐	

SPOUSE'S DENTAL COVERAGE			
GROUP #	MEMBER ID	CARRIER NAME	
CARRIER ADDRESS	CARRIER PHONE #	COVERAGE EFFECTIVE DATE	
What type of coverage is this policy?	SINGLE ☐	FAMILY ☐	

SPOUSE'S PRESCRIPTION COVERAGE			
GROUP #	MEMBER ID	CARRIER NAME	
CARRIER ADDRESS	CARRIER PHONE #	COVERAGE EFFECTIVE DATE	
What type of coverage is this policy?	SINGLE ☐	FAMILY ☐	

SPOUSE'S VISION COVERAGE			
GROUP #	MEMBER ID	CARRIER NAME	
CARRIER ADDRESS	CARRIER PHONE #	COVERAGE EFFECTIVE DATE	
What type of coverage is this policy?	SINGLE ☐	FAMILY ☐	

We declare that the foregoing information is true and correct to the best of my knowledge, information and belief. We understand that the Fund reserves the right to suspend or terminate our health coverage if it concludes that we have provided false or misleading information in this Declaration. We understand that if the spouse's employer offers group health insurance, the spouse must enroll in his/her employer's plan. I understand that if the spouse does not so enroll, he/she is ineligible to be covered as a dependent in the Fund's Plan. Finally, we understand that the spouse's group health plan from his/her employer is his/her primary insurance plan. The Fund will only consider spouse's claims for payment that have first been submitted to the spouse's employer's plan. If the spouse should change employment, or his/her eligibility for health coverage should change, We are required to notify the Fund and complete an updated Declaration of Spouse Health Coverage.

Member's Signature:		**Date:**	
Spouse's Signature:		**Date:**	