Teamsters Health & Welfare Fund

of Philadelphia and Vicinity

2500 MCCLELLAN AVE, SUITE 140 PENNSAUKEN, NJ 08109 (856) 382-2400
TOLL-FREE (800) 523-2846 FAX (856) 382-2420 www.teamsterfunds.com

New Employee Health & Welfare Coverage Form

Part I To Be Filled Out By Employer				
Employee Information		**Employer Information**		
1. Name of Employee		**8. Name of Employer** **Account Number**		
2. Social Security Number	**3. Date of Hire**	**9. Street Address (including room or suite no.)**		
4. Address		**10. City**	**11. State**	**12. Zip**
5. City	**6. State**	**13. Contact Phone Number**	**14. Contact Fax Number**	
7. Zip		**15. Email**		

Part II List the Employee's Days or Hrs Worked For Each Month Starting With Month of Hire

YEAR	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
YEAR	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC

Print Name:_____ Title:_____

Signature:_____ Date:_____

Part III To Be Filled Out By Health & Welfare Fund

1st Month of Contributions Due From Employer	1st Month of Eligibility
1st Day of Eligibility	Plus Additional Months Due At This Time From Employer

Reviewed By: _____

Once the form has been completed by the Employer, the Fund will review and notify the Employer via email as to your obligation for contributions due for the Employee stated above.

**Additional forms can be downloade from our website at www.teamsterfunds.com.
Search under "For Unions/Employers" the "Forms Gallery"