Print Form

PLEASE PRINT IN INK

TEAMSTERS HEALTH & WELFARE FUND OF PHILADELPHIA AND VICINITY
BENEFICIARY, CENSUS CARD and DECLARATION OF SPOUSE HEALTH COVERAGE

PLEASE COMPLETE BOTH SIDES OF THIS FORM

MEMBER'S INFORMATION:

(Last) _____ (First) _____ (Initial) _____ SS# _____

Address: _____ Date of Birth: _____

_____

Home Phone Number: _____ E-Mail Address: _____

Employer's Name: _____ Date Employed: _____ Local Union #: _____

Sex (circle one): Male Female Marital Status (circle one): Married Single Divorced Separated Widowed Other

***IF MARRIED, PLEASE PROCEED TO PAGE 2**

*****SPOUSE'S INFORMATION*****

(Name:) _____ (Date of Birth) _____ SS#_____

E-Mail Address: _____

Name & Address of Spouse's Employer: _____

Name & Address of Spouse's Insurance Carrier: _____

*****MEMBER DEPENDENT(S): (List dependent children and include E-Mail address, if applicable)*****

	Name	Sex	Date of Birth	SSN
1.	_____	_____	_____	_____
	1a. E-Mail Address: _____			
2.	_____	_____	_____	_____
	2a. E-Mail Address: _____			
3.	_____	_____	_____	_____
	3a. E-Mail Address: _____			
4.	_____	_____	_____	_____
	4a. E-Mail Address: _____			
5.	_____	_____	_____	_____
	5a. E-Mail Address: _____			

MEMBER DEATH BENEFIT BENEFICIARY:

Name of Beneficiary: _____ Relationship to Member: _____

Address of Beneficiary: _____

_____

By signing below I revoke any previous beneficiary designation. I also reserve the right to change this beneficiary designation and I certify that the information contained above is correct and accurate.

MEMBER'S SIGNATURE: _____ DATE: _____

Please proceed to Page 2

(Member's Name:) _____ (Member SS#)_____

*****DECLARATION OF SPOUSE HEALTH COVERAGE FORM*****

My spouse is (check one):

☐ employed full-time (full-time is defined as scheduled to work 32 or more hrs./wk., 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 hrs./wk., please sign on the signature lines and return to the Fund office)

☐ self employed

Spouse employer info: Employer's Address: _____

Employer's Phone #: _____Human Resource Contact: _____

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, dental, vision or prescription 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.

Does your spouse have other insurance coverage? YES ☐ NO ☐ Is the coverage below associated with a Flex Spending Acct? YES ☐ NO ☐			
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 our 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. We 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:**	

NOTE: **Once this form is complete, you may fax it to: 1-856-382-2402 or 1-856-382-2401**

Mailing Address: Teamsters Health & Welfare Fund of Philadelphia & Vicinity
2500 McClellan Avenue, Suite 140 ◦ Pennsauken, NJ 08109