Teamsters Health & Welfare Fund
of Philadelphia and Vicinity

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TOLL-FREE (800) 523-2846 • FAX (856) 382-2402 • www.teamsterfunds.com

YEARLY UPDATE
IMMEDIATE ACTION REQUIRED!

Dear Member:

Our office is in the process of updating our records 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, 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 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 in its entirety, including signatures and date, and return it to our office at your earliest convenience.

In the event 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,

MEMBER SERVICE DEPARTMENT
TEAMSTERS HEALTH & WELFARE FUND
OF PHILADELPHIA & VICINITY

DECLARATION OF SPOUSE HEALTH COVERAGE FORM

(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 #

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 Name: _____
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 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**.**

FOR THOSE SPOUSES COVERED UNDER A GROUP HEALTH PLAN THROUGH THEIR EMPLOYER*			
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 ☐**	

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

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** ☐			

******FOR THOSE SPOUSES WHOSE COVERAGE INCLUDES AN HRA (Health Reimbursement Account), FSA (Flex Spending Account), HSA (Health Spending Account) , OTHER******		
WHICH TYPE OF HEALTH SAVINGS ACCOUNT DO YOU HAVE?	**HSA □ HRA □ FSA □ OTHER_____**	
HOW MUCH DO YOU AND YOUR EMPLOYER CONTRIBUTE TO THE ACCOUNT?	**YOUR PORTION:** **$**	**EMPLOYERS PORTION:** **$**
IS THIS ACCOUNT ON CALENDAR YEAR OR PLAN YEAR?	**CALENDAR YEAR** **YES □ NO □**	**PLAN YEAR** **___/___/___ To ___/___/___**
If you are unsure of these answers, please consult with your Benefits Office or Human Resource Department.		

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 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 the 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**

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

Email: census@teamsterfunds.com