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) 382-2402 • www.teamsterfunds.com

LIFE EVENT: BENEFICIARY and CENSUS CARD
Beneficiary and Census Card must be completed in its entirety when adding a dependent(s) to your plan.
Required Documents as Follows:

Requirements for Member:

1. Need a copy of Member's Social Security Card.

Requirements to Add Spouse:

1. Member needs to complete a Beneficiary and Census Card.
2. Need a copy of the Marriage Certificate.
3. Need a copy of Spouse's Social Security Card.
4. Need to complete a Declaration of Spouse Health Coverage Form if not already completed on Beneficiary and Census Card. (This form is required to be completed once a year or when there are changes in spouse's employment/benefits.)

Requirements to Add Natural Child(ren) - *Newborn* - First 30 days of life:

1. Member needs to complete a Beneficiary and Census Card.
2. Need a copy of Crib Card or Heirloom Certificate from Hospital listing Member as parent.

Requirements to Add Natural Child(ren) - 31 or more days old:

1. Member needs to complete a Beneficiary and Census Card.
2. Need a copy of child(ren) Birth Certificate listing Member as parent.
3. Need a copy of child(ren) Social Security Card.

Requirements to Add Stepchild(ren):

1. Member needs to complete a Beneficiary and Census Card.
2. Need a copy of the Marriage Certificate (If we do not have one on file).
3. Need a copy of Stepchild(ren) Birth Certificate listing Member's Spouse as parent.
4. Need a copy of Stepchild(ren) Social Security Card.

PLEASE NOTE:

- **Dependent(s) will not be added to your plan until requested documents are received.**

If you should have any questions regarding the above, please contact the Member Services Department at 1-800-523-2846 or 1-856-382-2400.

Fax your forms: 1-856-382-2402 Email: census@teamsterfunds.com

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 Name _____(First) _____ (Middle Initial) _____ **SS#** _____
Address: _____**Date of Birth**: _____
City, State, Zip _____
Phone Number(s): (Home) _____ (Cellular) _____ (Work) _____
Member's 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

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

(Name:) _____ (Date of Birth) _____ SS#_____
Spouse's Phone Number: _____ Spouse's 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: _____			

** COMPLETION OF MEMBER DEATH BENEFIT BENEFICIARY IS REQUIRED **

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**: _____

If Married, 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

Email: census@teamsterfunds.com