Indiana Teamsters Health Benefits Fund
6007 S. Harding Street
Indianapolis, Indiana 46217
(317) 639-3573

Please Print (Complete **BOTH SIDES**)

For Office Use Only
Co. No.
Eff.
ID#

Full Name _____
(Last) (First) (M.I.)

Address _____
(Street) (City) (State) (Zip) (County)

Birth Date _____ Social Security No. _____

Phone No. _____ Local Union No. _____ Sex: M □ F □

Present Employer _____ Hire Date _____

1st Beneficiary _____ Perc._____% Relationship _____

2nd Beneficiary _____ Perc._____% Relationship _____

Date Signed _____ Signature _____

ANY CHANGES IN ELIGIBILITY MUST BE MADE WITHIN 30 DAYS OF CHANGE

NAMES OF DEPENDENTS

Print First name (in full) & include child's last name (if different)

Spouse _____ Social Security No. _____

Spouse Employment _____

Spouse Insurance _____

Children	Other Insurance? (Y /N)	Name of Insurance	Social Security No.	Sex M	Sex F

ATTESTATION

I hereby attest that all the information provided is true to the best of my knowledge.

I hereby agree to cooperate fully with the Plan in its efforts to verify eligibility for benefits and provide ALL documents required by the Plan. I understand that if I do not cooperate with the Plan, the Plan may deny or delay coverage for me and or my dependents.

I understand that if I knowingly or negligently give any false information and or neglect to report eligibility changes according to Plan language, my coverage may be canceled by the Plan. In addition, if any claims have been paid to me that would not have been paid had I given accurate information, I will have to repay those claims to the Plan.

Date: _____ Participant's Signature: _____

Please sign top and bottom portions of the card.
The card can be emailed to ITHBFMEMBER@LOCAL135.COM