# Teamsters Local 641 Welfare Fund

**714 Rahway Avenue, 2nd Floor, Union, NJ 07083**
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**www.641funds.org**

## 2024 FAMILY INFORMATION FORM

***PLEASE COMPLETE BOTH THE FRONT & BACK OF THIS FORM.**
**2024 CLAIMS WILL NOT BE PROCESSED UNTIL THIS FORM IS COMPLETED IN FULL AND RETURNED TO THIS OFFICE BY NO LATER THAN 2/28/2024**

_____ XXX-XX-_____
Participant Name Participant Social Security #

_____ _____
Address Phone

_____ _____
City State Zip Email

Is the **PARTICIPANT OR ANY MEMBER** of your family covered by **ANOTHER** group healthcare plan, **INCLUDING MEDICARE?**

☐ **YES - IF YES, you must complete Sections 1 & 2 & 3**

☐ **NO - IF NO, complete Sections 2 & 3**

## Section 1

Other policyholder's Name_____ Birthdate_____
Other policyholder's Address _____Soc. Sec. #XXX-XX-_____
Other Employer's Name_____
Name of other Insurance Co._____
Other insurance address/phone# _____
Group/policy number _____**Effective Date** _____
Dependent(s) covered under this policy _____

***YOU MUST ATTACH A COPY OF FRONT & BACK OF OTHER PLAN'S CARD(S)***

Other plan's coverage types ____ Single ____ Family ____Parent/Child
Other plan's type of plan ____ Medical ____ Dental ____ Prescription ____ Vision

## Section 2

***Does your spouse or dependent child(ren) work either part-time or full time?**

☐YES ☐NO

***If your spouse and/or dependent child(ren) work part-time or full time, you MUST attach a letter FROM their respective employer(s) STATING WHETHER or NOT health insurance benefits ARE AVAILABLE for them.**

The above answers are true and complete according to the best of my knowledge and belief. I authorize the release to **TEAMSTERS LOCAL 641 WELFARE FUND** of any additional information that may be required to establish the validity of this claim and further empower said company to disclose any information needed for medical review or study.

**YOU MUST NOTIFY THIS OFFICE WHEN ANY OF THE ABOVE INFORMATION CHANGES.**

***OVER***

# Section 3

**EFFECTIVE 1-1-2009 PURSUANT TO SECTION 111 OF THE MEDICARE, MEDICAID, AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM EXTENSION ACT OF 2007 (the "Act") A NEW SECTION TO THE MEDICARE SECONDARY PAYER STATUTE ("MSP"), 42 U.S.C § 1395y (b) (7) HAS BEEN ADDED, AND AS A RESULT THE FUND OFFICE IS REQUIRED TO IDENTIFY SOCIAL SECURITY NUMBERS FOR ALL PARTICIPANTS AND DEPENDENTS.**

**I certify that the data indicated below, for myself and my eligible dependents, is true and correct.**

**PLEASE PRINT**

| ***Full Name*** ***(LAST, FIRST)*** | ***Social Security #*** | ***D.O.B.*** | ***DOES DEPENDENT WORK ?*** | ***DOES HE/SHE HAVE HEALTH COVERAGE AVAILABLE?*** |
|---|---|---|---|---|
| Participant | | | | |
| If participant is a retiree<br>Name & address of current employer | | | | |
| Spouse | | | ____ **Y / N** ____ | ____ **Y / N** ____ |
| Spouse Employer Name & Address | | | | |
| Dependent | | | ____ **Y / N** ____ | ____ **Y / N** ____ |
| Dependent Employer Name & Address | | | | |
| Dependent | | | ____ **Y / N** ____ | ____ **Y / N** ____ |
| Dependent Employer Name & Address | | | | |
| Dependent | | | ____ **Y / N** ____ | ____ **Y / N** ____ |
| Dependent Employer Name & Address | | | | |

**PARTICIPANT'S SIGNATURE** **DATE**

**Failure to complete all required information will result in claims being pended until information is provided**