Teamsters Local 641 Welfare Fund

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2021 FAMILY INFORMATION FORM

***PLEASE COMPLETE BOTH THE FRONT & BACK OF THIS FORM.**
2021 CLAIMS WILL NOT BE PROCESSED UNTIL THIS FORM IS COMPLETED IN FULL AND RETURNED TO THIS OFFICE BY NO LATER THAN 2/28/2021

_____ 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 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