Teamsters Local 641 Welfare Fund

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2026 FAMILY INFORMATION FORM

***PLEASE COMPLETE BOTH THE FRONT & BACK OF THIS FORM.**
2026 CLAIMS WILL NOT BE PROCESSED UNTIL THIS FORM IS COMPLETED IN FULL AND RETURNED TO THIS OFFICE BY NO LATER THAN 2/27/2026

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

Address _____

City _____ State _____ Zip _____

Phone _____ 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_____
Other policyholder's Address _____
Birthdate _____ 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 hereby certify that the information provided below for myself, and my dependents is true and correct to the best of my knowledge.

*****IMPORTANT NOTICE.***** **Failure to complete all required information will result in claims being put on HOLD until the necessary information is submitted.**

Participant Full Name (print)		Social Security#	D.O.B.
Marital Status: (Circle One) Single - Never been married ☐ Married_____ (#of times) Widowed ☐ Divorced ☐			
If participate is a retiree Name & address of current employer:			
			DOES DEPENDANT WORK? / DOES HE/SHE HAVE HEALTH COVERAGE AVAILABLE?
Spouse Full Name	Social Security #	D.O.B.	☐Y/N☐ / ☐Y/N☐
Spouse Employer Name & Address			
Dependent Name	Social Security #	D.O.B.	☐Y/N☐ / ☐Y/N☐
Dependent Employer Name & Address			
Dependent Name	Social Security #	D.O.B.	☐Y/N☐ / ☐Y/N☐
Dependent Employer Name & Address			
Dependent Name	Social Security #	D.O.B.	☐Y/N☐ / ☐Y/N☐
Dependent Employer Name & Address			

_____ _____

PRINT PARTICIPANT'S NAME **DATE**

_____

PARTICIPANT'S SIGNATURE