Truck Drivers and Helpers Local Union
No. 355 Health and Welfare Fund
PO BOX 4417
Troy, MI 48099
(443) 573-3632 or (866) 621-7974
www.Teamsters355Benefits.org

Email Completed Documentation: enrollmentdocs@benesys.com

VITAL INFORMATION FORM

MEMBER Information: (*Please Print)*

Last: _____ First: _____ Middle: _____

Address/City/State/Zip: _____

Social Security Number: _____-_____-_____ Phone Number: (_____)_____Cell/Home_____

Date of Birth: _____/_____/_____ Gender: (*circle one*) Male Female

Marital Status: (*circle one*) Single Married Divorced Separated Widowed
Date of Marriage/Divorce/Separation: _____

Current Status: (*circle one)* Active Retired Disabled COBRA

Email Address: _____ Alternate Phone Number: _____

Medicare Claim Number: ***(This only applies when a member, a spouse, or a covered dependent is age 65 or older or on Medicare disability)***

Member # _____ **Spouse #** _____ **Dependent # & Name** _____

DEPENDENTS: - Include Spouse (If additional space is needed, please use 2nd sheet, be sure to include marriage certificate and birth certificates, please see dependent coverage letter)

FULL NAME	RELATION	BIRTH-DATE	SOCIAL SECURITY NUMBER
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

***Dependent children will remain eligible until the age of 26.*

BENEFICIARY(ies): (Death Benefits-Medical)

If a minor is named as beneficiary, insurance proceeds can only be paid to a legally appointed/qualified guardian.

NAME	RELATION	BIRTHDAY	S.S. #	ADDRESS/CITY/STATE/ZIP	%
_____	_____	___/___/___	____-___-____	_____	_____
(Primary)					
_____	_____	___/___/___	____-___-____	_____	_____
_____	_____	___/___/___	____-___-____	_____	_____
(Secondary)					
_____	_____	___/___/___	____-___-____	_____	_____

I agree to notify the Fund Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that stating false or misleading information or the omission of material information could be grounds for denial of benefits, including retroactively cancelling my coverage.

_____ _____

MEMBER SIGNATURE **Date**

(OVER)

OTHER INSURANCE INQUIRY

Signature Required Below

***Please complete this portion of the form if you, your spouse, or any of your dependents have other insurance coverage that you participate in, or if there has been any change in other insurance coverage*.**

General Information:

Name of Other Insured Person: _____

Other Insured Person Date of Birth: _____

Relationship to Member: _____

Information about Other Insurance Plan or Program:

Other Insurance Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Co. Phone #: (_____)_____

Policy/Group Number: _____

Effective date of coverage: _____ Is insurance active? _____

Termination date if applicable: _____

Coverage is: (*circle one*) Single Family

Children are covered until age: _____

Type of coverage: (*circle all that apply*) Medical Dental Vision Prescription

List covered dependents: _____

Coverage provides minimum value under the PPACA: (circle one) Yes No

Member Statement:

The above information is true and accurate to the best of my knowledge and belief. I also am aware of the fact that I must notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage.

I understand that if I make a false statement or materially misrepresent the information on this form, my coverage may be retroactively cancelled. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers as a result of any acts of fraud or material misrepresentation.

I Have No Other Insurance (Initial): _____

Member Signature:_____ Date: _____