

# Teamsters Local 641 Welfare Fund

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## 2009 FAMILY INFORMATION INQUIRY

COMPLETE **FRONT & BACK** OF THIS FORM PLEASE  
CLEARLY PRINT ALL INFORMATION

Participant Name \_\_\_\_\_

Social Security # \_\_\_\_\_

Is the **participant** or **any member** of your family covered by **another** group healthcare plan **including medicare**?

**YES** - if yes, complete Sections 1 & 2.

**NO** - if no, complete Section 2.

### Section 1

Policy holder Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Policy holder Address \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer's Name \_\_\_\_\_

Name of Insurance Co \_\_\_\_\_

Insurance address/phone# \_\_\_\_\_

Group / policy number \_\_\_\_\_ Effective Date \_\_\_\_\_

Dependent(s) covered under this policy \_\_\_\_\_

Type of Coverage  single  family  parent/child  
Type of Plan  Medical  Dental  Prescription  Vision

### Section 2

Does your spouse work?  YES  NO If yes, **name and full address** of spouse's employer.

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

If your spouse works and has **NO** benefits, attach a letter from spouse's employer stating **NO** benefits.

Do any dependent children work?  YES  NO If yes, name and address of employer.

Name \_\_\_\_\_

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.

Date \_\_\_\_\_ Signature of Participant \_\_\_\_\_

**YOU MUST NOTIFY THIS OFFICE WHEN ANY OF THE ABOVE INFORMATION CHANGES  
OVER ->**

