



TEAMSTERS WELFARE FUND OF
NORTHERN NEW JERSEY LOCAL 723

Union Trustee
John Humphrey

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Administrator

Employer Trustee
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2009 FAMILY INFORMATION INQUIRY

Complete **FRONT & BACK** OF THIS FORM
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 723 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 ->

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 Name, First

Social Security #

Date of Birth
Month Day Year

Participant

Spouse

Dependent Children

Participant's Signature

Date

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