Teamsters Local 922-Emoloyers Health Trust
7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046
Phone: 410-872-9500 Fax: 410-872-1275

☐ New
☐ Change
(check one)

NEW ENROLLMENT OR CHANGE FORM
(PLEASE PRINT EXCEPT FOR SIGNATURE)

Employee Name:_____ **SSN**:_____-_____-_____ **Sex:** M / F
(Last) (First) (MI) (Circle)

Address:_____ **DOB:**_____
(Street/P.O. Box)

_____ **Phone:**_____
(City) (State) (Zip)

Marital Status: (Check One) ☐ Single ☐ Married: Date_____ ☐ Divorced: Date_____ ☐ Widow/Widower

Employer Name:_____ **Hire Date:** _____

Address_____

Employment Status: ☐ Active ☐ Retired ☐ Disabled

Coverage Election: ☐ Individual ☐ 2-Party (self plus one) ☐ Family_____ ☐ OPT-OUT **Dental Plan:** ☐ Indemnity ☐ DPPO

DEPENDENT INFORMATION

Complete this section only if you are applying for dependent coverage. List your legal spouse and dependent children, up to age 25. By adding dependents, you agree to pay any additional cost sharing of the premium for 2-party or family. If additional space is required, please attach a separate sheet.

Name	SSN	Date of Birth	Sex	Relationship	Employment Status
					☐ No ☐ Yes If yes, indicate name of Employer: _____ Phone #: _____
					☐ No ☐ Yes If yes, indicate name of Employer: _____ Phone #: _____
					☐ No ☐ Yes If yes, indicate name of Employer: _____ Phone #: _____
					☐ No ☐ Yes If yes, indicate name of Employer: _____ Phone #: _____

OTHER INSURANCE INFORMATION

Please note that if your spouse is employed and coverage is available to him/her through that employer and the employer pays at least 50% of the premium for such coverage, if your spouse chooses not to elect the employer coverage, this plan will adjudicate your spouses claims as if the coverage were in force.

Is your spouse employed? ☐ No ☐ Yes Employer:_____ Does the employer offer insurance coverage? ☐ Yes ☐ No

Has your spouse elected such coverage? ☐ Yes ☐ No Does the employee pay any portion of the premium? ☐ Yes ☐ No If yes, what percentage _____

If other coverage exists, please provide the following: Policyholders Name:_____

Policy #:_____ Group #:_____ Name of Carrier_____

Claims Address:_____

Name (s) of covered dependents:_____

If you are retired or disabled, do you have Medicare? ☐ Yes ☐ No Part A____ Eff. Date_____ Part A____ Eff. Date_____

Does your spouse have Medicare? ☐ Yes ☐ No Part A____ Eff. Date_____ Part A____ Eff. Date_____

DEATH BENEFICIARY

This section to be completed by all active employees, employer paid retirees and retirees who self-pay for Life Insurance. If naming more than one beneficiary, indicate the percentage allotted to each beneficiary listed. If additional space is required, please attach a separate sheet.

Name of Beneficiary:_____ Relationship:_____ SSN:_____

Address:_____

I understand that if I make false statements on this Enrollment Form or any application for benefits or provide inaccurate documents to the Fund Administrator, I will lose my benefit eligibility and will be responsible for repaying the Health Trust the cost of any benefits improperly received by me and / or my dependents.

Signature_____ Date_____

RETAIN COLOR COPY FOR YOUR RECORDS – CONTAINS IMPORTANT PRIVACY INFORMATION ON REVERSE SIDE.