TEAMSTERS LOCAL 639 – EMPLOYERS

HEALTH & PENSION TRUST FUNDS

Teamsters Local 639 Center
3130 Ames Place, NE
Washington, DC 20018-1513
(202) 636-8181 / (800) 983-2699
Fax: (202) 526-7959

Coordination of Benefits
Health Fund

Please complete this form if your Spouse has other Health coverage.

Participant's Name: _____

Participant's Social Security Number: _____-_____-_____

Under the Plan's Coordination of Benefits provision, the following information is required. This form must be updated with current information whenever any changes occur.

1. Full name of your spouse _____
2. Spouse's Social Security Number _____
3. Spouse's Date of Birth _____
4. Name of Spouse's Employer _____
5. Address of Spouse's Employer _____
6. Telephone Number of Spouse's Employer _____
7. Name of Spouse's Group Insurance _____
8. Type of Coverage: Medical __Dental __Hospital __Prescription __Vision ____
   Check all that Apply
9. Effective Date _____Termination Date (if any) _____
10. Policy Number _____
11. Is this Individual or Family Coverage? (check one) Individual ____ Family _____

It is extremely important to complete the entire form and return it to the Fund Office. Your failure to do so will result in an unnecessary delay in establishing eligibility for your family and claims payment.