

# Central Pennsylvania Teamsters Health and Welfare Fund

JOSEPH J. SAMOLEWICZ, Administrator

MARTIN L. CULLEN, Assistant Administrator

1055 Spring Street, Wyomissing, PA 19610  
Mailing Address: P.O. Box 15224  
Reading, PA 19612-5224  
www.CentralPATeamsters.com



Phone: 610-320-5500  
TOLL FREE IN PA: 1-800-422-8330  
TOLL FREE IN USA: 1-800-331-0420  
FAX: 610-320-9236  
Benefit Coverage Inquiries: HWFund@centralpateamsters.com

**IMPORTANT**  
**PLEASE COMPLETE THIS FORM AND RETURN TO THE FUND OFFICE**  
**TO THE ATTENTION OF KIM F.**  
**ANNUAL COORDINATION OF BENEFITS (COB) FORM**

Participant's Name: \_\_\_\_\_  
Current Mailing Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Participant's I.D.# \_\_\_\_\_ Email Address: \_\_\_\_\_  
Home Telephone No. ( ) \_\_\_\_\_ Mobile Phone No. ( ) \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Spouse's Birthdate \_\_\_\_\_

**PLEASE COMPLETE THIS SECTION ONLY IF YOU OR YOUR DEPENDENTS ARE ENROLLED IN MEDICARE, DISABILITY MEDICARE, OR ESRD PROGRAM.**

Member YES NO	Spouse YES NO	Dependent Child Name
Medicare Eligibility due to: ___ Age ___ Disability ___ Kidney transplant ___ Dialysis	Medicare Eligibility due to: ___ Age ___ Disability ___ Kidney transplant ___ Dialysis	Medicare Eligibility due to: ___ Disability ___ Kidney transplant ___ Dialysis
Part A effective date: _____	Part A effective date: _____	Part A effective date: _____
Part B effective date: _____	Part B effective date: _____	Part B effective date: _____
MBI No. _____	MBI No. _____	MBI No. _____

(MBI Number is 11 characters consisting of alpha and numeric on ID Card)

**PLEASE COMPLETE ALL QUESTIONS REGARDING SPOUSE INFORMATION**

**Attention: Please read Notice of Waiver Rules on the next page**

Is Participant's spouse employed?    YES    NO    If YES, Effective Date \_\_\_\_\_  
If yes, please check either full time \_\_\_\_\_ or part time (less than 35 hours) \_\_\_\_\_  
Name of spouse's employer \_\_\_\_\_  
Address of spouse's employer \_\_\_\_\_  
Telephone number of spouse's employer ( ) \_\_\_\_\_  
Does your spouse have medical insurance through their employment?    YES    NO  
Type of coverage: Single Family Other: \_\_\_\_\_ I.D.# \_\_\_\_\_  
Name of insurance carrier \_\_\_\_\_  
Effective date of coverage \_\_\_\_\_  
Telephone number of insurance carrier ( ) \_\_\_\_\_  
Does this insurance provide an HSA account?    YES    NO  
Does this insurance provide an HRA account?    YES    NO

DO ANY OF YOUR DEPENDENTS OVER AGE 18 HAVE INSURANCE? **YES NO**  
CHILD NAME \_\_\_\_\_ COV IS UNDER CHILD \_\_\_ CHILD'S SPOUSE \_\_\_\_\_  
STEP PARENT \_\_\_ PARENT \_\_\_ INS. CARRIER \_\_\_ GOV. PROGRAM \_\_\_ EFF. DATE \_\_\_\_\_

**PLEASE COMPLETE FOR DEPENDENT(S) IF THE NATURAL PARENT IS NOT ON POLICY**

Is there a natural mother or father for your dependent child/children other than you or the current spouse listed on the previous page? **YES NO**

Natural mother/father's name and address \_\_\_\_\_

Natural mother/father's birthdate: \_\_\_\_\_

Name(s) of dependent children: \_\_\_\_\_

Natural mother/father's Employer's name and address: \_\_\_\_\_

Employer's telephone number: ( ) \_\_\_\_\_

Is there a domestic relations order or settlement agreement regarding responsibility to provide insurance coverage which could impact the Coordination of Benefits on behalf of your natural children? **YES NO**

If yes, a copy of such order/agreement is required and must be provided to the Fund Office.

Are any of the above-named dependent children covered by any other Medical coverage?

**YES NO** If yes, please complete the following:

Name of individual providing coverage: \_\_\_\_\_ ID# \_\_\_\_\_

Individual's relationship to child/children: \_\_\_\_\_

Name(s) of child/children covered under this policy: \_\_\_\_\_

Name of Medical Insurance Carrier \_\_\_\_\_ Effective Date \_\_\_\_\_

Medical Insurance Carrier's Telephone Number \_\_\_\_\_ Policy I.D.# \_\_\_\_\_

Is there an HRA account? **YES NO** Is there an HSA account? **YES NO**

**IMPORTANT:** Child/Children's place of residence (list name of child and complete address): \_\_\_\_\_

**IF COVERAGE IS UNDER A DEPENDENT OR FAMILY OPT OUT, DISREGARD THE BELOW IMPORTANT NOTICE REGARDING WAIVER RULES**

If your spouse works and Medical coverage is available through his/her employment, an election must be made to participate under that coverage even though your spouse may have to pay part of the cost. If your spouse is required to pay 100% of the premium, we must have a letter from the employer stating that fact, and then your spouse does not have to enroll. If your spouse elects not to participate, it is a violation of your Plan's waiver rules. This will result in your spouse's ineligibility as a dependent for benefit coverage purposes with our Fund. If you have any questions regarding this provision please contact the Fund Office at (610) 320-5500 or toll free nationwide at (800) 331-0420.