Please complete the attached TEAMSTERS INDUSTRIAL EMPLOYEES WELFARE FUND census form and return with the following documentation:

Member:

A COPY OF YOUR IDs (i.e. Driver's License, Passport, Birth Certificate, Social Security Card)

For Dependents you want to enroll in the plan:

COPY OF YOUR MARRIAGE CERTIFICATE, IF APPLICABLE

COPY OF YOUR SPOUSE'S IDs (i.e. Driver's License, Passport, Birth Certificate, Social Security Card)

COPY OF YOUR CHILDREN'S IDs (i.e. Birth Certificates, Social Security Cards)

DEPENDENT STATUS FORM FOR SPOUSE, IF APPLICABLE (completely filled out including information on spouse's employer)

ENROLLMENT FORM FOR ELIGIBLE DEPENDENTS AGES 19-26 (if your children are 19 years of age or older, he/she must also sign)

PLEASE NOTE THAT BENEFITS CANNOT BE PAID UNLESS WE HAVE THE NECESSARY DOCUMENTATION ON FILE.

If you have any questions or need assistance in completing the forms, please contact the Fund office at 201-867-3553.

TEAMSTERS INDUSTRIAL EMPLOYEES BENEFIT FUNDS
CENSUS FORM

IMPORTANT: NO BENEFITS WILL BE PAID UNLESS THIS FORM IS FULLY & PROPERLY COMPLETED, SIGNED & RETURNED TO THE FUND OFFICE

Please Print

Social Security Number	First Name	Middle Initial	Last Name

Street Address	Apt. #	City	State	Zip Code

Home Telephone #	Cellphone #	Employer	Date of Hire	Local Union #

Date of Birth

☐Male ☐ Female ☐Single ☐ Married ☐ Divorced ☐Widowed

Employment Status:
☐Active ☐Laid off ☐ Terminated

If laid off or terminated
date of lay off or termination

Name & Address of Spouse's Employer

Does Spouse have medical coverage where he/she works?
☐Yes ☐No

DEPENDENTS

Complete the information listed below for your spouse and all children under the Age of 26

The Fund requires a copy of your marriage certificate and dependents birth certificates. Benefits may be pended until this information is received.

First Name	Initial	Last Name	Social Security Number	Relation	Date of Birth

LIFE INSURANCE BENEFICIARY

I revoke all previous beneficiary designations and make the following nomination of beneficiary with respect to all pension and/or welfare benefits provided now or in the future under the rules of the Fund still reserving to myself the privilege of making future changes subject to Fund rules and procedures. If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries as survive me, unless otherwise stipulated herein. If no beneficiary survives me, settlement will be made as provided by the rules of the Fund and applicable law.

Social Security #	First Name	Last Name

Address	Apt. #	City	State	Zip Code

Relationship to You	Date of Birth

Social Security #	First Name	Last Name

Address	Apt. #	City	State	Zip code

Relationship to You	Date of Birth

☐Check & use reverse side for additional beneficiaries.

CERTIFICATION: I hereby certify that I have read the above information and that the information herein is true to the best of my knowledge.

Employee's Signature: _____ Date: _____

MAIL TO: TEAMSTERS BENEFIT FUNDS, 707 SUMMIT AVENUE, UNION CITY, NJ 07087-1737

For Office Use Only

INPUT BY: _____ DATE: _____

TEAMSTERS INDUSTRIAL EMPLOYEES WELFARE FUND
707 SUMMIT AVENUE, UNION CITY, NEW JERSEY 07087
PHONE 1 (866) 560-FUND

DEPENDENT STATUS FORM - SPOUSE

ANSWER ALL QUESTIONS

This form will be returned to you if all questions are not answered.

EMPLOYEE'S INFORMATION: (Please print) Email address: _____

Name of Employee: _____ Social Security #: _____

Home Telephone #: _____ Cell phone # (not required): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Employee's Date of Birth: _____ Employer's Name: _____

SPOUSE'S INFORMATION:

Spouse's Full name: _____ Spouse's Date of Birth: _____

Spouse's Social Security #: _____

Does your spouse reside at your address above? _____YES _____ NO

If NO, other address: _____

_____

Does your spouse work? ____ YES ____NO Does your spouse have other insurance? ____ YES ____ NO

IF SPOUSE WORKS OR HAS OTHER INSURANCE, PLEASE FILL OUT THE NEXT PAGE

THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE THE RELEASE TO TEAMSTERS INDUSTRIAL EMPLOYEES WELFARE FUND OF ANY ADDITIONAL MEDICAL INFORMATION THAT MAY BE REQUIRED TO ESTABLISH THE VALIDITY OF THE CLAIM AND FURTHER EMPOWER SAID COMPANY TO DISCLOSE ANY CLAIM INFORMATION NEEDED FOR MEDICAL CASE REVIEW OR STUDY.

In addition, I hereby designate my spouse as my Authorized Representative. I authorize my representative to receive any and all information that would be provided to me, and to act for me, in providing any information to the Plan that relates to any claim for coverage or benefits under the Plan. I understand that I have the right to revoke this authorization at anytime.

Member: _____ **Date:** _____

Spouse: _____ **Date:** _____

ANY FALSE ANSWERS TO THE ABOVE QUESTIONS OR SUBMISSION OF FRAUDULENT BILLS MAY RESULT IN THE LOSS OF ALL BENEFITS AND POSSIBLE CRIMINAL PROSECUTION.

Complete this page if your spouse works or has other insurance

Spouse's Employment Information

Name and address of spouse's employer: _____

_____

Date of Hire: _____ **Does spouse have other insurance?** _____ **YES** _____**NO**

If yes, please provide:

Effective Date of Coverage: _____ **Type of Coverage: Single**_____ **Family** _____

Plan Name: _____ **Member #:** _____

I _____, hereby authorize the employer listed above to release or disclose my availability to enroll in benefits and copies of my enrollment forms to the Teamsters Industrial Employees Welfare Fund for the current plan year.

Signature of spouse: _____ **Date:** _____

Please note that the TIE Welfare Fund requires that a spouse must enroll in his/her employer sponsored plan if the employer offers benefits at no cost.

THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE THE RELEASE TO TEAMSTERS INDUSTRIAL EMPLOYEES WELFARE FUND OF ANY ADDITIONAL MEDICAL INFORMATION THAT MAY BE REQUIRED TO ESTABLISH THE VALIDITY OF THE CLAIM AND FURTHER EMPOWER SAID COMPANY TO DISCLOSE ANY CLAIM INFORMATION NEEDED FOR MEDICAL CASE REVIEW OR STUDY.

Signature of member: _____ **Date:** _____

Signature of Spouse: _____ **Date:** _____

ANY FALSE ANSWERS TO THE ABOVE QUESTIONS OR SUBMISSION OF FRAUDULENT BILLS MAY RESULT IN THE LOSS OF ALL BENEFITS AND POSSIBLE CRIMINAL PROSECUTION.

Please return fully completed and signed original form to:

TIE Welfare Fund

707 Summit Avenue, 3rd Floor

Union City, NJ 07087

ENROLLMENT FORM FOR ELIGIBLE DEPENDENTS AGES 19-26

YOU MUST COMPLETE A SEPARATE FORM FOR EACH DEPENDENT YOU WANT COVERED UNDER THE TIE WELFARE PLAN

If you have not already provided a copy of his/her Birth Certificate, please submit with the completed form.

A. Employee Information:

Last Name	First Name	Middle Initial (MI)

Mailing Address	Social Security #

City	State	Zip code

Gender ☐ F ☐ M	Date of Birth (Month/Day/Year)	Home Phone number	Cell/Phone Number

Employer Name:

B. Dependent Enrollment: Relationship to you: ☐ Natural Son/Daughter ☐ Adopted ☐ Stepchild ☐ other (explain):

Dependent's Last Name	First Name	MI	Sex	DOB	SS#
			☐ F ☐ M		

Is dependent currently enrolled in the Plan? ☐ Yes ☐ No Is dependent married? ☐ Yes ☐ No
Is dependent employed? ☐ Yes ☐ No Is dependent's spouse employed? ☐ Yes ☐ No (if yes, complete C)
Does your adult dependent (age 19 and older) have other employer sponsored coverage available, whether enrolled or not:
through his/her employer? ☐ Yes ☐ No through his/her spouse's employer? ☐ Yes ☐ No (if yes, complete D)

C. Dependent's Employer Name, Address and Phone number: If you answered yes, provide employer name, address and phone number. If the child is married and spouse is working, provide information on employer for working spouse.

Dependent's Employer Name: _____
Employer Address and Phone number: _____
Dependent's Spouse's Employer Name: _____
Employer Address and Phone number: _____

D. Other Health Care Coverage Information: Complete the following section if your dependent is covered or will be covered under other group health coverage.

Policyholder's Name:	Policyholder relationship to Dependent: ☐Self ☐Spouse ☐Parent	Policyholder DOB:	Group and Policy #:	Effective Date:

Employer Name:	Address:	Phone #:

Insurance Company/Claims Administrator Name:	Address:	Phone #:

SIGNATURES ARE REQUIRED ON THE NEXT PAGE

Employee Statement: I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I understand that if I conceal information, provide false information, or otherwise mislead the Plan, my child's eligibility for Plan coverage will be terminated retroactively and I will be liable for any claims that were paid erroneously based on the false or misleading information. I hereby authorize the Plan to request any and all information and documentation deemed necessary by the Trustees, including Social Security Earnings, to administer and enroll me and my dependents in the Plan.

Signature_____ Date_____

Adult Dependent's Statement: I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I authorize the Plan Office in conjunction with my employer to verify the existence or availability of other coverage that may be available to me through that employment. I understand that if I conceal information, provide false information, or otherwise mislead the Plan, my eligibility for Plan coverage will be terminated retroactively and my parent and I will be liable for any claims that were paid erroneously based on the false or misleading information. I hereby authorize the Plan to request any and all information and documentation deemed necessary by the Trustees, including Social Security Earnings, to administer and enroll me in the Plan.

Signature_____ Date_____

Adult Dependent's Spousal Statement: I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I authorize the Plan Office in conjunction with my employer to verify the existence or availability of other coverage that may be available to my spouse through my employment. I understand that if I conceal information, provide false information, or otherwise mislead the Plan, my eligibility for Plan coverage will be terminated retroactively and my spouse and his/her parent will be liable for any claims that were paid erroneously based on the false or misleading information. I hereby authorize the Plan to request any and all information and documentation deemed necessary by the Trustees, including Social Security Earnings, to administer and enroll my spouse in the Plan.

Signature_____ Date_____

Please return fully completed and signed original form to:

TIE Welfare Fund

707 Summit Avenue, 3rd Floor

Union City, NJ 07087