ENROLLMENT DOCUMENTATION CHECKLIST

****IMPORTANT PLEASE READ FIRST****

If we do not receive ALL of the necessary documents – you will NOT have insurance or receive your medical cards.

NECESSARY DOCUMENTS FOR THE MEMBER:

1) CENSUS FORM
2) DENTAL ELECTION FORM
3) A COPY OF YOUR IDENTIFICATION – Acceptable documents – Driver's License, Passport or Birth Certificate **IDENTIFICATION CANNOT BE EXPIRED AND NO OTHER FORM BESIDES THE ONES LISTED WILL BE ACCEPTED.**

IF YOU ARE ADDING DEPENDENTS ONTO THE PLAN, BELOW ARE THE NECESSARY DOCUMENTS WE NEED ON THEIR BEHALF:

1) COPY OF YOUR MARRIAGE CERTIFICATE
2) COPY OF YOUR SPOUSE'S BIRTH CERTIFICATE – Or other Acceptable documents (Driver's License or Passport Birth) **IDENTIFICATION CANNOT BE EXPIRED**
3) COPY OF YOUR CHILDREN'S BIRTH CERTIFICATE - (If **Adopted or Legal Guardianship** - a copy of adoption papers proving you are the parent)
4) **YEARLY CLAIM FORM FOR SPOUSE** (filled out completely including information on spouse's employer)
5) **YEARLY CLAIM FORM FOR DEPENDENT CHILDREN AGES 19 & OLDER** (he/she must also sign)

****BENEFITS WILL NOT BE PAID UNLESS WE HAVE THE NECSSARY DOCUMENTATION ON FILE.****

If you have any questions or need assistance in completing the forms, please contact the Fund office at 201-867-3553 ext. 134

LISTA DE COMPROBACIÓN DE DOCUMENTACIÓN DE INSCRIPCIÓN

****IMPORTANTE POR FAVOR LEA PRIMERO****

Si no recibimos TODOS los documentos necesarios - NO tendrá seguro ni recibir sus tarjetas médicas.

DOCUMENTOS NECESARIOS PARA EL MIEMBRO:

1) FORMULARIO CENSAL
2) FORMULARIO DE ELECCIÓN DENTAL
3) UNA COPIA DE SU IDENTIFICACIÓN – Documentos aceptables – La identificación de licencia de conducir, pasaporte o certificado de nacimiento **NO PUEDE EXPIRAR Y NO SE ACEPTARÁ NINGÚN OTRO FORMULARIO ADEMÁS DE LOS ENUMERADOS.**

SI ESTÁ AGREGANDO DEPENDIENTES AL PLAN, A CONTINUACIÓN SE PRESENTAN LOS DOCUMENTOS NECESARIOS QUE NECESITAMOS EN SU NOMBRE:

1) COPIA DE SU CERTIFICADO DE MATRIMONIO
2) COPIA DEL CERTIFICADO DE NACIMIENTO DE SU CÓNYUGE – U otros documentos aceptables (licencia de conducir o pasaporte de nacimiento) **IDENTIFICACIÓN NO PUEDE SER CADUCADO**
3) COPIA DEL CERTIFICADO DE NACIMIENTO DE SUS HIJOS - (Si es **adoptado o tutela legal** - una copia de los documentos de adopción que demuestren que usted es el padre)
4) **FORMULARIO DE RECLAMO ANUAL PARA EL CÓNYUGE** (completado completamente incluyendo información sobre el empleador del cónyuge)
5) **FORMULARIO DE RECLAMACIÓN ANUAL PARA NIÑOS DEPENDIENTES DE 19 AÑOS O MÁS** (también debe firmar)

LOS BENEFICIOS NO SE PAGARÁN A MENOS QUE TENGAMOS LA DOCUMENTACIÓN NECESARIA EN EL ARCHIVO.

Si tiene alguna pregunta o necesita ayuda para completar los formularios, comuníquese con la oficina del Fondo al 201-867-3553 ext. 134.

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: ________________

	HORIZON DENTAL NETWORK 1-800-433-6825		HEALTHPLEX/EASTERN DENTAL NETWORK 1-800-982-5529	
	In-Network Patient Cost	Out-of-Network Patient Cost	In-Network Patient Cost	Out-of-Network Patient Cost
Oral Exam (2x per calendar year)	$0	Difference between allowed amount and charge.	$0	You pay the full charge.
Fluoride Treatment	$0	Difference between allowed amount and charge.	$0	You pay the full charge.
Sealants	$0	Difference between allowed amount and charge.	$15 per tooth to age 14	You pay the full charge.
Prophylaxis	$0	Difference between allowed amount and charge.	$0	You pay the full charge.
X-rays	$0	Difference between allowed amount and charge.	$0	You pay the full charge.
Space Maintainers	30%	30% of allowed amount plus difference between allowed amount and charge.	$0	You pay the full charge.
Amalgam Restorations	30%	30% of allowed amount plus difference between allowed amount and charge.	$0	You pay the full charge.
Composite Restorations	30%	30% of allowed amount plus difference between allowed amount and charge.	$0	You pay the full charge.
Denture Adjustments	30%	30% of allowed amount plus difference between allowed amount and charge.	$0	You pay the full charge.
Denture Repairs	30%	30% of allowed amount plus difference between allowed amount and charge.	$0	You pay the full charge.
Simple Extractions	30%	30% of allowed amount plus difference between allowed amount and charge.	$0	You pay the full charge.
Root Canal Therapy	30%	30% of allowed amount plus difference between allowed amount and charge.	$0	You pay the full charge.

	HORIZON DENTAL NETWORK 1-800-433-6825		HEALTHPLEX/EASTERN DENTAL NETWORK 1-800-982-5529	
	In-Network Patient Cost	Out-of-Network Patient Cost	In-Network Patient Cost	Out-of-Network Patient Cost
Root scaling & Plaining	30%	30% of allowed amount plus difference between allowed amount and charge.	$0	You pay the full charge.
Gingivectomy	30%	30% of allowed amount plus difference between allowed amount and charge.	$0	You pay the full charge.
Periodontal Maintenance	30%	30% of allowed amount plus difference between allowed amount and charge.	$0	You pay the full charge.
Osseous Surgery	30%	30% of allowed amount plus difference between allowed amount and charge.	$75 (per quadrant)	You pay the full charge.
Surgical Extractions	50%	50% of allowed amount plus difference between allowed amount and charge.	$0	You pay the full charge.
Partial Bony Extractions	50%	50% of allowed amount plus difference between allowed amount and charge.	$0	You pay the full charge.
Complete Bony Extractions	50%	50% of allowed amount plus difference between allowed amount and charge.	$0	You pay the full charge.
Partial Dentures	50%	50% of allowed amount plus difference between allowed amount and charge.	$0	You pay the full charge.
Crowns	50%	50% of allowed amount plus difference between allowed amount and charge.	$0	You pay the full charge.
Orthodontic	You pay the balance of the allowed amount over $1,000	You pay the balance of the full charge over $1,000	You pay $500 for patients up to age 19 or $1,250 for those over age 19	You pay the full charge.

As you can see there is a substantial difference in your cost and the dental benefit you receive depending upon the Network you choose and whether your dentist is In-Network or Out-of-Network. **Therefore, it is important that you choose the Dental Network that is right for you and your family.** Along with comparing the costs in the chart on the previous pages, you should also **check to see if your dentist is in one or both networks.**

To find In-Network dentists in the Horizon Dental Plan go to
https://doctorfinder.horizonblue.com/dentists/plan-horizon-dental-ppo
and enter your zip code.

To find In-Network dentists in the HealthPlex/Eastern Dental Plan go to
https://www.healthplex.com/our_dentists
and enter the group number "GJ2090" for New Jersey providers and "GJ2090A" for New York providers.

MY ELECTION:

After consideration of the coverages, costs and provider networks, I select as the dental network option for me and my family for the 2022 Plan year the following checked network **(Check one)**:

HORIZON DENTAL NETWORK: ______

HEALTHPLEX/EASTERN NETWORK: _______

________________________________	______________________
Member Name	Social Security Number
________________________________	______________________
Member Signature	Date

RETURN THIS FORM to:
Teamsters Industrial Employees Welfare Fund
707 Summit Avenue
Union City NJ 07087

The information in this document is for highlight purposes only. While every effort is made to ensure accuracy, if there is a discrepancy between the information in this document and the Summary Plan Description, the SPD will govern.

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

2022 Plan Year - DEPENDENT STATUS FORM - SPOUSE

ANSWER ALL QUESTIONS

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

MEMBER'S INFORMATION: (Please print clearly) Email address: ______________________

Name of our member: ______________________________ Social Security #: ______________

Home Telephone #: ________________________ Cell phone #: ________________________

Street Address: ____

City: __________________________________ State: _____ Zip Code: ____________

Member's Date of Birth: ____________ Employer's Name: ______________________________

SPOUSE'S INFORMATION:

Spouse's Full name: ______________________________ Spouse's Date of Birth: ____________

Spouse's Social Security #: ______________________ Spouse's Cell phone __________________

Spouse's Email address ______________________________________

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

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.

****IF SPOUSE WORKS OR HAS OTHER INSURANCE, THE BACK OF THIS FORM MUST BE COMPLETED****

Complete this side if your spouse works or has other insurance

Spouse's Employment and/or Insurance 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 #:** ___________________________

Is this insurance through your employer _____ Medicare _____ Medicaid ______ Other _______

If you checked Other, please explain ____

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 2022 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 mail fully completed and signed original form to:
TIE Welfare Fund
707 Summit Avenue, 3rd Floor
Union City, NJ 07087

PLEASE DO NOT FAX THIS FORM

2022 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 ☐ N through his/her spouse's employer? ☐ Yes ☐ N (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 REVERSE SIDE OF THIS FORM

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

PLEASE DO NOT FAX THIS FORM