TEAMSTERS INDUSTRIAL EMPLOYEES WELFARE FUND

DEPENDENT ENROLLMENT FORM

Enclosed are the new dependent enrollment forms for the 2024 calendar year. These enrollment forms apply to all spouses and dependents ages 19-26, that you wish to enroll in the TIE Welfare Plan.

Please note that these forms have changed. Feel free to make copies of these forms or contact the Fund Office at 1-866-560-FUND for additional forms.

It is important that you return the **original fully completed forms** as soon as possible to:

TIE Welfare Fund
303 Molnar Drive, 1st Floor
Elmwood Park, NJ 07407

No claims will be paid for your spouse and/or your dependents (between the ages of 19-26) unless the forms are fully completed. ***If the dependent enrollment forms are not returned to the Fund Office by December 8, 2023, benefit payments for services beginning January 1, 2024 will be suspended.***

INSTRUCTIONS

1. Complete the applicable form for your spouse and each adult dependent that you wish to be covered under the Plan. Adult dependent is construed to mean any child covered under the Plan who has reached his or her 19th birthday.
2. If you have more than one dependent, you will need to complete a separate form for each dependent.

This form must be completed for all dependents you want covered under the Plan. You must complete the form in its entirety, sign, date and return the original forms to the Fund Office. If your dependent is 19 or older, he/she must also sign the form.

If your dependent is between the ages of 19 and 26, please provide the following if you have not previously done so:

1. a copy of the dependent's birth certificate
2. for adopted children or those placed for adoption, a copy of the adoption paperwork
3. for a stepchild, a copy of your marriage certificate.

Failure to submit the signed and dated original enrollment forms by December 8, 2023, will result in a suspension of benefit coverage for your dependent(s) effective January 1, 2024.

2024 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
303 Molnar Drive, 1st Floor
Elmwood Park, NJ 07407

PLEASE DO NOT FAX THIS FORM