TRUCKING EMPLOYEES OF NORTH JERSEY WELFARE FUND, INC.
303 MOLNAR DRIVE, 1ST FLOOR, ELMWOOD PARK, NJ 07407
PHONE 1 (866) 560-FUND

2024 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 TRUCKING EMPLOYEES OF NORTH JERSEY WELFARE FUND, INC. 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 Trucking Employees of North Jersey Welfare Fund for the 2024 Plan year.

Signature of spouse: _____ Date: _____

Please note that the TENJ 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 TRUCKING EMPLOYEES OF NORTH JERSEY WELFARE FUND, INC. 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:
TENJ Welfare Fund
303 Molnar Drive, 1st Floor
Elmwood Park, NJ 07407

PLEASE DO NOT FAX THIS FORM