ADULT CHILD ENROLLMENT FORM

Member Information

1. Name: Last _____ First _____

SS/ID# _____

2. Home Address: Street _____

City _____ State _____ Zip _____

Child Information

3. Name: Last _____ First _____

SS# _____

4. Home Address: Street _____

City _____ State _____ Zip _____

5. Date of Birth: __/__/____ 6. Marital Status: Married ☐ Single ☐

7. Sex: Male ☐ Female ☐

8. Is the child covered under any other group health insurance? Yes ☐ No ☐

If Yes, What is the name of the other Insurance Company: _____

Policy-Holder Name:_____Policy#_____
Effective Date:_____ Medical ☐ Dental ☐

9. **Notify Fund of Other Coverage Eligibility**: You and/or your child understand that you must notify the Teamsters Local 671 Health Services and Insurance Plan as soon as the child becomes eligible for any employer sponsored health coverage to coordinate with the Teamsters Health Plan. General coordination of benefit guidelines will be applied.

_____ _____

Members Signature **Date**

_____ _____

Child's Signature **Date**