TEAMSTERS LOCAL 671

HEALTH SERVICES AND INSURANCE PLAN FOR RETIRED MEMBERS

APPLICATION FOR RETIREE MEDICAL BENEFITS
AND BENEFICIARY DESIGNATION

NAME _____

ADDRESS _____

_____

S.S.# _____TEL._____ DATE OF BIRTH_____

DO YOU HAVE ANY OTHER HEALTH INSURANCE? YES_____ NO_____

IF YES, NAME AND ADDRESS OF INSURANCE COMPANY _____

_____POLICY # _____

If There is a change in marital status, please provide details: Date of change: _____
____ Widowed _____ Divorced

SPOUSE INFORMATION:
NAME _____

S.S. # _____ DATE OF BIRTH_____

DOES SPOUSE HAVE ANY OTHER HEALTH INSURANCE? YES_____ NO _____

IF YES, NAME & ADDRESS OF INSURANCE COMPANY _____

_____ POLICY # _____

IS OTHER INSURANCE PROVIDED THROUGH:

ACTIVE EMPLOYMENT _____ RETIREE BENEFITS_____

NAME & ADDRESS OF EMPLOYER WHO PROVIDES COVERAGE:_____

_____

I certify that the above information is correct and I authorize the release of information necessary to process claims to the Teamsters Local 671 Health Services and Insurance Plan for Retired Members. I will notify the Health Services Office of any change in my marital status or change in other medical insurance coverage. I understand that falsifying information on this statement could jeopardize any benefits offered to me.

_____ _____

Retiree's Signature Date Spouse's Signature Date

TEAMSTERS LOCAL 671

Health Services And Insurance Plan For Retired Members

Death Benefit

Name of Member _____ Social Security Number _____

Address of Member _____

Designation of Beneficiary

Primary

Name and Address _____

Social Security Number _____

IN THE EVENT THAT THE PRIMARY BENEFICIARY PREDECEASES THE MEMBER, PLEASE DESIGNATE A SECONDARY BENEFICIARY:

Secondary

Name and Address _____

Social Security Number _____

Retiree's Signature _____ Date _____