TEAMSTERS LOCAL 671A HEALTH SERVICES AND INSURANCE PLAN   ANNUAL INFORMATION REQUEST FORM - CALENDAR YEAR 20__

SEE BACK OF FORM FOR ADDITIONAL INFORMATION

Member Name ______________________________ TSJ# or Social Security #__________ Phone # __________ Cell Phone # __________ Employer Name __________

Address__________________ APT #_____ City______________ State_____ Zip______ Marital Status: __ Married __Single __Divorced __ Separated __Widow Date of change ________

☐Check here if new address

Any changes in the information on this form should be reported to Local 671A Fund Office immediately.

PERSONAL INFORMATION - PLEASE PRINT CLEARLY

Name (First/Last) List all Participants covered under this Plan		Sex M/F	Date of Birth	Social Security #	Marital Status	Street Address If a Participant DOES NOT live at the address above, write address below	City	State, Zip	Phone Number/ Custodial Parent's Phone Number (if applicable)	Custodial Parent's Name (if applicable)	Employed? Y/N	Employer Name
	Self		/ /									
	SP		/ /									
	CH		/ /									
	CH		/ /									
	CH		/ /									
	CH		/ /									
	CH		/ /									
	CH		/ /									

OTHER INSURANCE INFORMATION (NOT INCLUDING LOCAL 671A HSIP)

CHECK (√) what coverage each Participant has other than Local 671A HSIP

Name (First/Last) If a Participant has any other insurance besides Local 671A HSIP, include a copy of your insurance card with this form		Name of Insurance Company Example: Medicare, Husky, Anthem, Cigna, etc…	Is this Insurance through an Employer? Y/N	Does the Participant Pay for this Insurance? Y/N	Effective Date	Medical	Dental	Rx	Vision
	Self				/ /				
	SP				/ /				
	CH				/ /				
	CH				/ /				
	CH				/ /				
	CH				/ /				
	CH				/ /				
	CH				/ /				

AUTHORIZATIONS FOR DIRECT PAYMENT, CREDITS, AND RELEASE OF INFORMATION (FORM WILL BE RETURNED IF NOT SIGNED OR IF ANY STATEMENTS BELOW WHICH REQUIRE RESPONSE ARE NOT COMPLETED.)

Exchange of Health Information: I understand that, in accordance with federal law, the Plan will communicate and exchange my health information and that of my dependents with other entities such as hospitals, health care providers, pharmacies, insurers, and other benefit plans relating to treatment, payment and health care operations of the Plan. __YES __NO

Payment Authorization: I authorize payment to the provider for all benefits for services rendered to me and my eligible dependents by hospitals, physicians, dentists, and other health care providers. __YES __NO (Payments for providers participating in the Plan's medical and dental PPO networks are always paid directly to the provider.)

Claim against another Party: Do you have an injury or illness caused by someone else or for which someone else may be liable (including workers' compensation). __YES __NO (See back of form)

Local Specific Credits (if applicable): I request automatic reimbursement of any unpaid allowable expenses related to my health care claims and those of my eligible dependents from Local Specific Credits, if available under the Plan. __YES__NO (See back of form)

False Information: I understand that knowingly filing a false or incomplete claim or concealing information relating to the claim, is a fraudulent act and may be a crime, may result in loss of coverage for me and my dependents, and may require that we repay all amounts paid by the Plan and all costs of collection, including interest and attorney fees.

MEMBER'S SIGNATURE*______________________________DATE:__________

18+ YEAR OLD DEPENDENT SIGNATURE______________________DATE:__________

18+ YEAR OLD DEPENDENT SIGNATURE______________________DATE:__________

SPOUSE'S SIGNATURE ______________________________DATE:__________

18+ YEAR OLD DEPENDENT SIGNATURE______________________DATE:__________

18+ YEAR OLD DEPENDENT SIGNATURE______________________DATE:__________

*Custodial parent or legal guardian may sign where coverage is for minor dependent children of member.

Please return the signed form to Teamsters Local 671A HSIP, 22 Britton Drive, Bloomfield, CT 06002