

# TBT ENROLLMENT FORM

Send completed form to: Teamsters Benefit Trust (TBT) • P.O. Box 5820 • Fremont, CA 94537-5820 • (510) 796-4676 • (800) 533-0119

**Please Check One:**  New Employee  Current Participant  
 Change (Complete only those items that have changed. Submit proof of marriage, divorce or addition of dependents.)

## PRIMARY COVERED PERSON INFORMATION (Employee, Retiree, Surviving Spouse or COBRA participant)

Social Security Number	Local Union	For Office Use Only			
Last Name, First Name, Middle Initial (If this is a name change, show your former name in parentheses.) <i>Please Print</i>					Male/Female
Home Address <i>Please Print</i>			Apt. #	City	State Zip Code
Birth Date (Month-Day-Year)	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Single with Dependent Children			Home Phone ( )	
Name of Employer (Last Employer, if Retired)			Date Hired or Retired (Month-Day-Year)	Work Phone ( )	

## DEPENDENT INFORMATION

RELATIONSHIP TO PRIMARY COVERED PERSON (son, daughter, stepson, stepdaughter, court appointed guardian)	IF ADDING OR DELETING A DEPENDENT (Submit divorce decree, marriage license, birth certificate, court documents)	ELIGIBLE DEPENDENTS List all eligible dependents as defined in the <i>Guide to Your Benefits</i> . <i>Please Print:</i> Last Name, First Name, Middle Initial	SOCIAL SECURITY NUMBER (Required for Each Dependent)	DATE OF BIRTH (Month-Day-Year)
Legal Spouse	Add <input type="checkbox"/> Delete <input type="checkbox"/>			
	Add <input type="checkbox"/> Delete <input type="checkbox"/>			
	Add <input type="checkbox"/> Delete <input type="checkbox"/>			
	Add <input type="checkbox"/> Delete <input type="checkbox"/>			
	Add <input type="checkbox"/> Delete <input type="checkbox"/>			
	Add <input type="checkbox"/> Delete <input type="checkbox"/>			

<b>IF ADDING OR DELETING A SPOUSE DUE TO MARRIAGE, DIVORCE OR DEATH:</b> ➔	Date of <i>Marriage</i> (Month-Day-Year)	Date of <i>Divorce</i> (Month-Day-Year)	Date of <i>Death</i> (Month-Day-Year)
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## BENEFICIARY DESIGNATION—FOR LIFE INSURANCE —ACTIVE PARTICIPANTS ONLY (Not for Retirees or COBRA Participants)

Social Security Number	Last Name, First Name, Middle Initial <i>Please Print</i>	Date of Birth (Month-Day-Year)	Relationship
Home Address <i>Please Print</i>			

## OTHER INSURANCE INFORMATION

- Is employer-sponsored group medical coverage available at your spouse's workplace?  YES  NO  
 If available, has your spouse chosen not to participate in such medical coverage, or chosen lower benefit levels, because of your coverage through Teamsters Benefit Trust?  YES  NO
- If you first became an eligible employee within the last three months, did you have prior medical coverage?  YES  NO  
 If yes, what was the name of the trust fund, insurance company or plan? \_\_\_\_\_  
 \_\_\_\_\_ When were you last covered? (Month/Year) \_\_\_\_\_

I CERTIFY THAT ALL INFORMATION PROVIDED ON THIS ENROLLMENT FORM IS TRUE AND CORRECT, AND THAT ONLY ELIGIBLE DEPENDENTS (AS DEFINED IN THE GUIDE TO YOUR BENEFITS) ARE LISTED.

Signature of Primary Covered Person (Employee, Retiree, Surviving Spouse or COBRA Participant)

Date Signed (Month-Day-Year)

**Please Note: Claims will not be paid unless this enrollment form is on file!**

August 1997, Form G2