New York State Teamsters Council Health and Hospital Fund

PO Box 4928 • Syracuse, New York 13221-4928 • Telephone: 315-455-9790 • Fax 315-234-1046 • e-mail: benefits@nytfund.org

ANNUAL COORDINATION OF SPOUSE BENEFITS FORM

***** Must be completed by Spouse's Employer*** Return via mail/fax/email**

Teamster Member Name: _____ Teamster ID# or SS#:_____

Spouse's Name: _____

PART 1: SPOUSE UNEMPLOYED

1. If spouse does not work for an employer and has NO OTHER INSURANCE, please indicate reason:
   ☐ Unemployed ☐ Self Employed ☐ Retired ☐ Disabled ☐ Other:_____

   Member MUST sign and date below and return the form.

2. If Spouse is unemployed, retired or disabled and is **ENROLLED IN OTHER INSURANCE**, including Medicare, you must complete the following sections: ***Member must sign, date and return form***
   SECTION B: Current Insurance Coverage **SECTION D:** Spouse Identification Card Information

Member's Signature: _____ **Date:** _____

PART 2: SPOUSE EMPLOYED

1. Is employee eligible for health benefits? ☐ NO ☐ YES
   ☐ No, Part-Time ☐ No, Not Offered ☐ No, Other _____
   If No, please complete the following sections: **SECTION C:** Employer Information

2. If **YES** and Employee is **ELIGIBLE** for Health Benefits **PLEASE READ THE FOLLOWING CAREFULLY AND COMPLETE THE SECTION THAT APPLIES.**
   Part 3 - if **ONLY** offering is a **HDHP with HSA** (High Deductible Health Plan with Health Savings Account)
   Part 4 - if **ONLY** offering is a **SINGLE PLAN** such as a **PPO / HRA / FSA / HMO INSURANCE PLAN**
   Part 5 - if both **HDHP with HSA** and **OTHER INSURANCE PLANS** are offered

---

PART 3: HDHP supported by – HSA – ONLY OFFERING: ☐ YES ☐ NO

a. Employee is **NOT ENROLLED**, please complete **SECTION C:** Employer Information and return.
b. Employee is **ENROLLED**, please complete the following and return:
   SECTION B: Current Insurance Coverage
   SECTION C: Employer Information
   SECTION D: Spouse Identification Card Information

PART 4: PPO / HRA / FSA / HMO INSURANCE PLAN (NOT HSA)

1. ☐ Employee is **ENROLLED** ☐ Employee is **NOT ENROLLED**
   SECTION A: Contribution Rate and Wage **MUST** be completed even if employee is **NOT ENROLLED**
   SECTION B: Current Insurance Coverage if **ENROLLED**
   SECTION C: Employer Information
   SECTION D: Spouse Identification Card Information

PART 5: BOTH: HDHP with HSA and PPO / HRA / FSA / HMO INSURANCE PLANS ARE OFFERED

1. ☐ Employee is **ENROLLED:** ☐ **HSA** ☐ **PPO / HRA / FSA / HMO – OTHER PLAN**
PLEASE PROVIDE AN OUTLINE OF ALL PLANS AVAILABLE AND THE COST
   SECTION A: Contribution Rate and Wage of the LEAST EXPENSIVE Plan available – NON HSA Plan
   SECTION B: Current Insurance Coverage
   SECTION C: Employer Information
   SECTION D: Spouse Identification Card Information

2. ☐ Employee is NOT **ENROLLED:**
PLEASE PROVIDE AN OUTLINE OF ALL PLANS AVAILABLE AND THE COST
   SECTION A: Contribution Rate and Wage of the LEAST EXPENSIVE Plan available – NON HSA Plan
   SECTION C: Employer Information

SECTION A: EMPLOYEE BENEFIT CONTRIBUTION RATE AND WAGE INFORMATION

EMPLOYER PLEASE NOTE:

- Employee contribution rates should reflect January 1, 2022 benefit coverage
- If **MULTIPLE** plans are offered, please provide the **least expensive** benefit plan available **excluding** plans supported by an **HSA (Health Savings Account)**
- Coordination of Benefits is a requirement under the New York State Teamsters Health Fund and **regardless of open enrollment restrictions**. The spouse is required to enroll in their Benefit Plan if the Fund determines the spouse meets the Fund's requirements.

Complete the EMPLOYEE'S contribution rate for Medical and Prescription coverage **only** regardless if the employee is enrolled.

Single Contribution:	$_____	☐ Weekly	☐ Bi-Weekly	☐ Monthly
Family Contribution:	$_____	☐ Weekly	☐ Bi-Weekly	☐ Monthly
Employee's Gross Average Earnings:	$_____	☐ Weekly	☐ Bi-Weekly	☐ Monthly

---

SECTION B: CURRENT INSURANCE COVERAGE (REQUIRED):

Please Provide the Employee's **CURRENT** Insurance Coverage

MEDICAL	**RX PLAN**	**DENTAL**
☐ Single	☐ Single	☐ Single
☐ Two Person	☐ Two Person	☐ Two Person
☐ Family	☐ Family	☐ Family
Original Eff. Date: _____	Original Eff. Date: _____	Original Eff. Date: _____
Carrier Name: _____	Carrier Name: _____	Carrier Name: _____
Carrier Addr: _____	Carrier Addr: _____	Carrier Addr: _____
Policy #: _____	Policy #: _____	Policy #: _____

SECTION C: SPOUSE'S EMPLOYER INFORMATION: Please Print Clearly

Company Name: _____

Company Address: _____

Company Phone Number: _____

Company Fax Number: _____

Company Representative: _____

Representative E-Mail Address: _____

Representative Signature: _____ Date: _____

SECTION D: SPOUSE IDENTIFICATION CARD INFORMATION

Please advise your employee to submit a copy of their insurance card(s) for **ALL** coverage (FRONT and BACK); this would include an identification card for Medical, Prescription and Dental if applicable.

IF THIS INFORMATION IS NOT PROVIDED CLAIMS WILL BE SUSPENDED