New York State Teamsters Council – UPS Retiree Health Fund

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ANNUAL COORDINATION OF SPOUSE BENEFITS FORM

Teamster Member Name: ______________________________ Teamster ID# or SS#: ________________

Spouse's Name: _____________________________

Part 1

Is your spouse employed?

☐ Yes ☐ No

If yes, your spouse's employer is required to complete the sections below. Your spouse may not be eligible to participate in this Fund if certain conditions are present.

If no, please sign and return this form to the Fund office.

Member Signature: ____ Date: __________________

*******To be completed by spouse's Employer********

Part 2 – No Coverage

- If the Employee is not offered health insurance, please check the following box and complete **Section C:** Employer Information.

  ☐ **Not offered insurance**

Part 3 – HSA Plan

- If the Employee is enrolled or only offered a High Deductible Health Plan supported by an HSA, please check the appropriate box below and complete **Sections C**: Employer Information.

  ☐ **Enrolled in High Deductible Health Plan w/HSA**

  ☐ **Only Offered a High Deductible Health Plan w/HSA but not enrolled**

- If the Employee is offered a High Deductible Health Plan w/HSA but enrolled in another option, please complete Part 3.

Part 4 – All Other

SECTION A: EMPLOYEE BENEFIT CONTRIBUTION RATE AND WAGE INFORMATION

- Please provide the Employee Contribution Rates as of January 1, 2025 for Medical and Prescription for the least expensive benefit plan available (excluding plans supported by an HSA) 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: 2025 INSURANCE COVERAGE (*ONLY REQUIRED IF ENROLLED*):

Please Provide the Employee's **2025** Insurance Coverage:

MEDICAL	**RX PLAN**	**DENTAL**
☐ Single	☐ Single	☐ Single
☐ 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: EMPLOYER INFORMATION: Please Print Clearly

Company Name: ____

Company Address: ____

Company Phone Number: ____

Company Fax Number: ____

Company Representative: ____

Representative E-Mail Address: ____

Representative Signature: ____ Date: ____________________