

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, 2022 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: 2022 INSURANCE COVERAGE (ONLY REQUIRED IF ENROLLED):

Please Provide the Employee's **2022** Insurance Coverage:

MEDICAL

- Single
- Family

RX PLAN

- Single
- Family

DENTAL

- Single
- 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: _____
