New York State Teamsters Council Health and Hospital Fund

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Dependent Eligibility Form

Teamster Member Name:
ID#

Re: Eligibility for Dependent(s)

In order to establish and/or update eligibility for the above named dependents, the following information is required.

☒ Name of Natural Father _____

☒ Date of Birth of Natural Father _____

☒ Is Natural Father employed? ☐ Yes ☐ No
If yes, is Natural Father enrolled in coverage?
☐ Not enrolled ☐ Enrolled Single coverage* ☐ Enrolled Family coverage*
*Please submit a copy of the insurance ID cards.

☒ If there is a Divorce Decree, Separation Agreement, Family Court Order, or other legal documents stating **custody AND insurance responsibility of your dependent**, please submit a copy of **ENTIRE** document(s).

OR CHECK THE BOX BELOW

➡ ☐ To the best of my knowledge, there are no legal documents addressing custody and insurance responsibility for my dependent(s).

☒ Does the dependent(s) live with: ☐ Member ☐ Natural Father ☐ All together ☐ Other
If other, please explain: _____

☒ Is the Natural Father married? ☐ Yes ☐ No ☐ Unknown

☒ Any other relevant information:
_____
_____

I attest and certify that this information I have provided is accurate and truthful.
Member's Signature _____ **Date** _____