New York State Teamsters Council – UPS Retiree Health Fund

PO Box 4928 • Syracuse, New York 13221-4928 • Telephone: 315.455.9790 • Facsimile 315.234.1047 • e-mail: benefits@nytfund.org

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, 2023 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 **2023** Insurance Coverage:

MEDICAL	**RX PLAN**	**DENTAL**
☐ Single ☐ Family	☐ Single ☐ Family	☐ 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: _____