New York State Teamsters Council Health and Hospital Fund

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NATURAL MOTHER EMPLOYER FORM

PLEASE NOTE: This Form must be completed by the Natural Parent's Employer
If this form is not returned it will delay eligibility and claim payment

Teamster Member Name: _____ Teamster ID#:_____

Natural Parent Name: _____ Date of Birth: _____

Are health benefits offered ? ☐ Yes ☐ No

Is the employee eligible for health benefits ? ☐ Yes ☐ No

If YES, please complete the EMPLOYEE'S portion of the contribution rate for Medical and Prescription 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

If the employee is currently enrolled in benefits please complete the following 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 #: _____

EMPLOYER INFORMATION: Please Print Clearly

Company Name: _____

Company Address: _____

Company Phone Number: _____

Company Fax Number: _____

Company Representative: _____

Date: _____

NATURAL PARENT UNEMPLOYED : Teamster member must complete and sign and date below.

If natural parent does not work for an employer and has NO OTHER INSURANCE, please indicate reason:

☐ Unemployed ☐ Self Employed ☐ Retired ☐ Disabled ☐ Other:_____

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

REV 11/2017