



TEAMSTERS UNION LOCAL NO. 35

SERVICE, INDUSTRIAL AND PROFESSIONAL EMPLOYEES

HEALTH PLANS

620 U.S. ROUTE 130 TRENTON, NEW JERSEY 08691 (609) 585-3600 FAX: (609) 585-3929

MANDATORY SUBSCRIBER/DEPENDENT VERIFICATION FORM

Complete ALL Items (Please Print)

Member Name: _____
Last First Middle

Social Security No. ____ - ____ - ____ Sex: Male__ Female__ Date of birth: ____/____/____

Address _____
Street City County State Zip Code

Phone No. (Inc. Area Code) _____ Marital Status _____
(Single, Married, Widowed, Separated, Divorce)

Name of Employer _____ Date of Hire: _____

Name of Spouse _____ Employed Yes
 No

Spouse's date of birth ____/____/____

Social Security Number of Spouse ____ - ____ - ____

If yes, name & address of employer _____

First Name	Last Name	*MANDATORY* Social Security No.	Date of Birth (Month/Day/Year)	Relationship

Notice Regarding Fraudulent Information- Any person who knowingly and with intent to defraud this Fund, any insurance company or other person, and submits incorrect information on this verification form, files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading, information concerning any fact material thereto, is considered committing a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Member Signature _____ Date _____