



Teamsters' National Benefit Plan (the "Plan")

DUAL COVERAGE FORM

(Please provide information below and return completed form to our office)

- My spouse has their own group health insurance plan, details listed below:
- My spouse does **not** have a group health insurance plan.
- My spouse had previous coverage, which terminated on: _____ dd/mm/yy

| | | | |
|-------------------|--------------------------------------|---|------|
| SPOUSE NAME | | SPOUSE DATE OF BIRTH dd/mm/yy | |
| INSURANCE COMPANY | | POLICY # | ID # |
| EMPLOYER | EFFECTIVE DATE _____ dd/mm/yy | ARE CHILDREN COVERED UNDER THIS PLAN? IF SO, UNTIL WHAT AGE? _____ | |

If your spouse is covered under another plan, we follow the guidelines of the Canadian Life and Health Insurance Association (CLHIA). We are the primary payor for your expenses. Your Spouse's benefit provider is the primary carrier for their expenses. Dependent children become the primary responsibility of the plan of the parent who has the earliest birthdate in the year (month, day).

| SPOUSAL GROUP INSURANCE DETAILS | | |
|---|----------|----|
| EXTENDED HEALTH ANNUAL DEDUCTIBLE IF APPLICABLE | \$ _____ | |
| DENTAL ANNUAL DEDUCTIBLE IF APPLICABLE | \$ _____ | |
| ARE THE FOLLOWING BENEFITS INCLUDED: | YES | NO |
| EYE EXAMS | | |
| EYEWEAR | | |
| BASIC DENTAL | | |
| MAJOR DENTAL | | |
| ORTHODONTIC | | |

I understand that the information provided relates to coverage being provided under a health and welfare trust and I certify that the information is true and correct to the best of my knowledge.

PLAN MEMBER NAME

CLIENT ID / CERTIFICATE #

SIGNATURE

DATE (dd/mm/yy)

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