VERIFICATION FORM
REQUIRED DOCUMENTS

Employee Name:_____
Social Security Number:_____

All required documents MUST contain the date (*i.e.,* birth date, marriage date or household bill/account date), your name and your dependent's name. Personal information such as social security numbers, account numbers, and financial information may be marked out for confidential purposes.

FOR SPOUSE:

1. A copy of your marriage certificate **AND**

2. A completed Affidavit of Spousal Health Care Coverage (enclosed) **AND**

3. ONE OF THE FOLLOWING:

- A copy of the front page of your most recently filed (2020 or 2021) federal tax return confirming this dependent is your spouse **OR**

- A document dated within the last 60 days showing current relationship status such as a recurring monthly household bill or statement of account. The document must list your spouse's name, the date and your mailing address. Healthcare bills will not be accepted as proof of eligibility as healthcare coverage is being verified.

FOR CHILDREN UP TO AGE 26:

1. ONE OF THE FOLLOWING:

- A copy of the child's birth certificate or adoption certificate naming you or your spouse as the child's parent. Please note the document must list the first and last names of the child and parent(s) **OR**

- A copy of the court order naming you or your spouse as the child's legal guardian or document showing the child is placed in your foster care **OR**

- A copy of the Qualified Medical Child Support Order requiring you to provide healthcare for the child.

**Note for a stepchild: If you are covering a stepchild you must also provide documentation of your current relationship to your spouse as requested above.*

FOR DISABLED CHILDREN:

1. A copy of the front page of your most recently filed (2020 or 2021) federal tax return listing the child as your tax dependent **AND**

2. A copy of the child's birth certificate or adoption certificate naming you or your spouse as the child's parent. Please note the document must list the first and last names of the child and parent(s) **OR** a copy of the court order naming you or your spouse as the child's legal guardian.

SUBMISSON PROCESS

After collecting all of your REQUIRED DOCUMENTS **AND** completing the VERIFICATION FORM, simply submit the documents and verification form by one of the following methods:

BY FAX:

Fax the Required Documents and the Fund Office at 202-526-7959.

BY MAIL:

Mail the Required Documents and the Verification Form to Fund Office P.O. Box 99489, Troy, MI 48098-9998. Please do not staple or highlight any of the documents. Please do not mail original documents.

By my signature on this form, I certify and warrant to Teamsters Local 639 Health Trust Fund that (1) all information on this form is true, correct, and current as of the date signed and (2) all **"REQUIRED DOCUMENTS"** that are submitted are authentic. I understand any attempt to maintain coverage for an ineligible dependent may be subject to appropriate legal action by the Fund against me.

Signature: _____ **Date:** _____