



Teamsters Health & Welfare Fund

of Philadelphia and Vicinity

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YEARLY OPEN ENROLLMENT MEDICAL BENEFIT OPTION CHANGE FORM

Effective January 1, 2027, I _____
(Member's Name)

want to change the medical benefit option for myself and my eligible dependents.

I am currently covered under: (check one)

- () Horizon Blue Care PPO Program
() Horizon Blue Care PPO Program (IN NETWORK ONLY)

I want to change my coverage to: (check one)

- () Blue Care PPO Program
() Horizon Blue Care PPO Program (IN NETWORK ONLY)

Member's Signature: _____

Member's ID Number/SSN: _____

Date: _____

For the benefit option change to be effective January 1, 2027, this form must be completed and received in the Fund office by **November 30, 2026**. Please Note: The level of coverage (Platinum or Gold) you will have during the coverage year, depends on your, and if applicable, your spouse, participation in the annual wellness screening program.

You may send the completed form by mail to the above address, fax to 856-382-2402, or email to census@teamsterfunds.com.

If you wish to stay with the same coverage, you currently have, you do **not** need to complete this form. Your coverage option will remain the same.

If you have questions about your benefits, please call Member Services at 800-523-2846, option 1.



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