Michigan Conference of Teamsters Welfare Fund

Serving Teamster families since 1949

UNION TRUSTEES
H.R. Hillard
Ronald E. Holzgen
Kevin D. Moore
Paul M. Kozicki

2700 Trumbull Avenue, Detroit, Michigan 48216
(313) 964-2400
www.mctwf.org

Executive Director
Richard Burker

EMPLOYER TRUSTEES
Raymond J. Buratto
Earl D. Ishbia
Robert W. Jones
José C. Rosario

CERTIFICATION OF RESUMPTION OF COVERED EMPLOYMENT

Please fax this completed form to MCTWF at 313-964-3144 or submit the requested information via e-mail to cctldept@mctwf.org.

This is to certify that ____,
(Participant's Name/Please Print)

Last 4 digits
S.S. # XXX / XX /________, has resumed active employment as of ______/_____/_______.
(month / day / year)

I recognize my responsibility to resume contributions on the above participant's behalf, commencing with the week in which the employee resumed active employment.

Employer Representative Signature: ____

Employer Representative Name/Title:____

Employer Name: ____

MCTWF Company ID#: ____

Employer Address: ____

Employer Phone #:____________________________ Date Signed: _________________________

Upon receipt of this certification, MCTWF will notify its medical, dental and behavioral health networks of the participant's renewed eligibility. Network eligibility files are updated each Monday with information received by MCTWF by the previous Thursday.

If you have any questions, please contact your Account Services Representative at 313-964-2400.

Thank you.

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