MICHIGAN LABORERS' HEALTH CARE FUND

YEARLY COORDINATION OF BENEFITS AND DEPENDENT STATUS STATEMENT FOR ______________

(PLEASE TYPE OR PRINT CLEARLY)

PARTICIPANT'S NAME:			BIRTH DATE:
HOME ADDRESS (STREET NAME AND ADDRESS):		STATE:	ZIP CODE:
SEX:	SOCIAL SECURITY No.:	LOCAL UNION No.:	TELEPHONE NUMBER:

MARITAL STATUS (Circle One): Married Single Divorced Widowed Separated

SPOUSE'S NAME:	BIRTH DATE:	SOCIAL SECURITY No.:
DEPENDENT'S NAME:	BIRTH DATE:	RELATIONSHIP:

Are you or your dependents covered by any other medical insurance? This includes Medicare, Blue Cross-Blue Shield, HMO plans, PPO plans, etc.

Circle One: Yes No If Yes, please complete the section below:

Is this policy (Circle One): Group Individual

NAME OF OTHER INSURANCE:		TELEPHONE NUMBER: ( )
ADDRESS OF OTHER INSURANCE:		
POLICY NUMBER:	GROUP NUMBER:	POLICYHOLDER'S NAME:
FAMILY MEMBERS COVERED UNDER THE POLICY:		

Are you or your dependents covered by any other Dental Insurance?

Circle One: Yes No If Yes, please complete the section below:

Is this policy (Circle One): Group Individual

NAME OF OTHER INSURANCE:		TELEPHONE NUMBER: ( )
ADDRESS OF OTHER INSURANCE:		
POLICY NUMBER:	GROUP NUMBER:	POLICYHOLDER'S NAME:
FAMILY MEMBERS COVERED UNDER THE POLICY:		

*SPOUSE'S EMPLOYER:	DATE EMPLOYED:
*SPOUSE'S EMPLOYER'S ADDRESS:	

*PLEASE NOTE: **IF SPOUSE IS EMPLOYED AND YOU HAVE INDICATED THAT SPOUSE HAS NO OTHER INSURANCE COVERAGE, PLEASE HAVE SPOUSE'S EMPLOYER COMPLETE REVERSE SIDE OF THIS FORM.**

PLEASE READ CAREFULLY AND SIGN BELOW

I hereby certify that the above statements are true and complete to the best of my knowledge and belief. I understand that if I intentionally falsify any of the above information, Medical claims may be denied and I may be subject to litigation by the Fund. I also understand that I must notify the Fund of any changes in the above information within 30 days of any change.

Member's Signature ______________________________ Date ______________

Spouse's Signature ______________________________ Date ______________

**This form must be completed in detail once each year to avoid delay in the processing of your claims.

MICHIGAN LABORERS' HEALTH CARE FUND
6525 Centurion Drive
Lansing, MI 48917-9275
877-MI-LABOR Phone: (517) 321-7502 Fax: (517) 321-7508

Due to the fact that your spouse is employed and may have other group health coverage (that you may not be aware of), it is necessary for your spouse's employer to complete the bottom portion of this form.

Payment of pending and/or future claims will be considered upon receipt of this completed form.

Member's Name: ______________________________

Member's Social Security No.: ______________________ Local Union No.: ____________

Spouse's Name: ______________________ Spouse's Soc. Sec. No.: ______________________

THIS PORTION MUST BE COMPLETED BY SPOUSE'S EMPLOYER

(PLEASE TYPE OR PRINT)

Do you cover ______________________ with group health coverage? Yes ☐ No ☐

If yes, please indicate the effective date: ______________________

If coverage has been terminated, please indicate date: ______________________

Please indicate Carrier's Name: ______________________

Carrier's Address: ______________________

Carrier's Telephone No.: ______________________

If no insurance coverage is provided, please indicate reason: ______________________

____

Name of Employer: ______________________

Address: ______________________

Telephone No.: ______________________

Signature of Person Completing Form: ______________________

Title: ______________________ Date: ______________________