

# MICHIGAN LABORERS' HEALTH CARE FUND – GROUP 007004429

Managed for the Trustees by : TIC INTERNATIONAL CORPORATION

## HEALTH CARE (BCBSM) ENROLLMENT FORM AND YEARLY COORDINATION OF BENEFITS AND DEPENDENT STATUS STATEMENT

(Please Type or Print Clearly)

Participant's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Member ID (MID) OR SS# \_\_\_\_\_ Telephone Number \_\_\_\_\_  
Address: \_\_\_\_\_

Check if new  
**MARITAL STATUS** (Check One):    Married    Single    Divorced    Widow    Separated

Spouse's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security No. \_\_\_\_\_

Dependent's Name \_\_\_\_\_ Relationship \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security No. \_\_\_\_\_

### FAMILY CONTINUATION COVERAGE

**-NOTE: PLEASE LIST ALL ELIGIBLE ADULT DEPENDENT CHILDREN 19-26 ON THE REVERSE SIDE OF THIS FORM-**

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

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

Is this policy (Check One)    Group    Individual

Name of Other Insurance \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address of Other Insurance \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Policyholder's Name \_\_\_\_\_ Effective Date of Coverage \_\_\_\_\_

Family Members Covered under the Policy \_\_\_\_\_

Are you or your dependents covered by any other dental insurance?

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

Is this policy (Check One)    Group    Individual

Name of Other Insurance \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address of Other Insurance \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Policyholder's Name \_\_\_\_\_ Effective Date of Coverage \_\_\_\_\_

Family Members Covered under the Policy \_\_\_\_\_

### 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 information on this form within 30 days of any change.

**Member's Signature:** \_\_\_\_\_

Date: \_\_\_\_\_

**Spouse's Signature:** \_\_\_\_\_

Date: \_\_\_\_\_

Return this form to: Michigan Laborers' Health Care Fund, 6525 Centurion Drive, Lansing MI 48917

# MICHIGAN LABORERS' HEALTH CARE FUND

## ADULT CHILD UNDER AGE 26

### PLEASE LIST ALL ELIGIBLE ADULT DEPENDENT CHILDREN 19-26 BELOW

(If you have more than two adult children under age 26, please use a separate sheet of paper)

The Health Care and Education Affordability Reconciliation Act of 2010 requires the Fund to extend dependent child coverage up to age 26. Dependents qualify whether they are married or unmarried. As of January 1, 2013, if your dependent has another offer of employer-based coverage (such as through his or her job) they are still eligible to enroll under this Plan.

NAME OF ADULT CHILD

SOCIAL SECURITY NUMBER

COMPLETE ADDRESS OF ADULT CHILD

BIRTH DATE

#### FAMILY CONTINUATION COVERAGE

Is your adult child under age 26 covered by any other medical insurance? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.

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

Is your adult child eligible to enroll in employer-based coverage? Yes No

If yes, is your adult child enrolled in employer-based coverage? Yes No

If Yes, please complete the section below:

Effective date of other medical insurance: \_\_\_\_\_ Is this policy (check 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

NAME OF ADULT CHILD

SOCIAL SECURITY NUMBER

COMPLETE ADDRESS OF ADULT CHILD

BIRTH DATE

#### FAMILY CONTINUATION COVERAGE

Is your adult child under age 26 covered by any other medical insurance? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.

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

Is your adult child eligible to enroll in employer-based coverage? Yes No

If yes, is your adult child enrolled in employer-based coverage? Yes No

If Yes, please complete the section below:

Effective date of other medical insurance: \_\_\_\_\_ Is this policy (check 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