MICHIGAN LABORERS' HEALTH CARE FUND
RETIREE INFORMATION FORM

(TO BE COMPLETED BY DISABLED AND RETIRED PARTICIPANTS)

If you, your spouse, or any eligible dependent children have Medicare or a Social Security Disability Award please forward a copy to the Fund office.

Name____

Member ID or SS#____________________ Date of Birth____________

Do you have a **SOCIAL SECURITY DISABILITY AWARD**? _____NO ____YES
If yes – submit a copy of your Social Security Disability Award along with this form

Please provide your Medicare insurance information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card

- OR -

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A and Part B

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name ____________________

Medicare Claim Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___ ___ Sex ☐ M ☐ F

Is Entitled To: Effective Date

HOSPITAL (Part A) ____________

MEDICAL (Part B) ____________

▲This is for YOUR Medicare Information▲

If you do not have Medicare – are you "eligible" to enroll in Medicare? _____NO _______YES

Marital Status ___SINGLE ___MARRIED ___WIDOWED ___DIVORCED ___SEPARATED

Spouse's Name____

Spouse's SS#__________________ Spouse's Date of Birth__________________

Does your **Spouse** have a SOCIAL SECURITY DISABILITY AWARD? _____NO ____YES
If yes – submit a copy of your Social Security Disability Award along with this form

Please provide your Medicare insurance information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card

- OR -

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A and Part B

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name ____________________

Medicare Claim Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___ ___ Sex ☐ M ☐ F

Is Entitled To: Effective Date

HOSPITAL (Part A) ____________

MEDICAL (Part B) ____________

▲This is for your SPOUSE'S Medicare Information▲

If your spouse does not have Medicare – is he/she "eligible" to enroll in Medicare?
_______NO _________ YES

Do you have any eligible dependent children that should be covered under the Michigan Laborers' Health Care Fund? ___NO __YES

IF "YES", STATE FULL NAME OF DEPENDENT, SOCIAL SECURITY NUMBER AND DATE OF BIRTH

Dependent Name	Date of Birth	Social Security Number

If any of the children listed above have MEDICARE, please indicate which child and their MEDICARE EFFECTIVE DATE. **PLEASE SEND A COPY OF THEIR MEDICARE CARD WITH THIS COMPLETED FORM.**

IF ANY OF THE ABOVE INFORMATION CHANGES, IT IS YOUR RESPONSIBILITY TO CONTACT THE FUND OFFICE, IMMEDIATELY.

I/WE CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE AND BELIEF.

_____________ ______________________________________
Date Signature of Participant

_____________ ______________________________________
Date Signature of Spouse

Daytime telephone number where you can be reached: ______________________________________
(PLEASE INCLUDE AREA CODE)

Please mail your completed form to:

Michigan Laborers' Health Care Fund
6525 Centurion Drive
Lansing, MI 48917
(877) 645-2267