

MICHIGAN LABORERS'
HEALTH CARE FUND - GROUP 29804
 Managed for the Trustees by: TIC INTERNATIONAL CORPORATION
BLUE CROSS BLUE SHIELD OF MICHIGAN (BCBSM) ENROLLMENT FORM &
YEARLY COORDINATION OF BENEFITS AND DEPENDENT STATUS STATEMENT
 (Please Type or Print Clearly)

Participant's Name Birthdate: Member ID or Social Security Number Telephone number

Address:

Marital Status (check box to right of selection): **Married** **Single** **Divorced** **Widowed** **Separated**

Spouse's Name Birthdate Social Security No.

Dependent's Name Relationship Birthdate Social Security No.

FAMILY CONTINUATION COVERAGE - NOTE: PLEASE LIST ALL ELIGIBLE DEPENDENT CHILDREN UNDER AGE 26 ON REVERSE SIDE OF 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:

Type of 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

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 (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 vision insurance?

Check 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

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:** _____

Return this form to:

Michigan Laborers' Health Care Fund, 6525 Centurion Drive, Lansing, MI 48917-9275

MICHIGAN LABORERS' HEALTH CARE FUND

ADULT CHILD UNDER AGE 26 FOR WHICH THE EXTENSION OF COVERAGE IS REQUESTED

(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. However, if your dependent has another offer of employer-based coverage (such as through his or her job) they are not eligible to enroll under this Plan.

NAME OF ADULT CHILD

SOCIAL SECURITY NUMBER

COMPLETE ADDRESS OF ADULT CHILD

BIRTH DATE

FAMILY CONTINUATION COVERAGE

Are you, your dependents or adult child(ren) 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:

Effective date of other medical insurance: _____ Is this policy (check one) Group or 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

Are you, your dependents or adult child(ren) 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:

Effective date of other medical insurance: _____ Is this policy (check one) Group or Individual?

Name of Other Insurance

Telephone number

Address of Other Insurance

Policy Number

Group Number

Policyholder's Name

Family Members Covered under the Policy

PLEASE READ CAREFULLY AND SIGN BELOW

I have read and understand the participation conditions and requirements for adult dependent children up to age 26. By signing below, I certify that: 1) the information provided above is correct; 2) All adult child coverage is contingent upon me maintaining my eligibility under the Plan; 3) I will be financially responsible for any claims paid for ineligible adult children if the claims were paid based upon inaccurate or misleading information I provide. 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: