

**MICHIGAN LABORERS' HEALTH CARE FUND  
RETIREE ELECTION FORM**

I have read and understood the provisions for continuing coverage under the Plan. I have checked the type coverage that I am eligible for. **I understand that my election of dental coverage is/was a one (1) time election and that I cannot add or cancel dental benefits without writing to the Board of Trustees.**

**It is the intent of the Board of Trustees to review these rates and make appropriate adjustments on a regular basis.**

NAME \_\_\_\_\_

MEMBER ID or SS# \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

LOCAL UNION # \_\_\_\_\_ TELEPHONE NUMBER \_\_\_\_\_

DO YOU OR YOUR SPOUSE HAVE A SOCIAL SECURITY DISABILITY AWARD?      YES      NO  
(If yes, please provide a copy with this election form)

DO YOU OR YOUR SPOUSE HAVE MEDICARE?      YES      NO  
(If yes, please provide a copy with this election form)

MARITAL STATUS      SINGLE      MARRIED      WIDOWED      DIVORCED      SEPARATED

SPOUSE'S NAME \_\_\_\_\_

SPOUSE'S SS# \_\_\_\_\_ SPOUSE'S DATE OF BIRTH \_\_\_\_\_

DO YOU HAVE ANY ELIGIBLE DEPENDENT CHILDREN THAT SHOULD BE COVERED BY THIS PLAN?      YES      NO

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

\_\_\_\_\_  
\_\_\_\_\_

*If any of the above information changes, it is your responsibility to immediately contact the fund office.*

**Please Indicate Type Of Coverage Elected**

**MEMBER ONLY:** HEALTH CARE - \*Contact Fund Office for current rates

**FAMILY:** HEALTH CARE - \*Contact Fund Office for current rates

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

\_\_\_\_\_  
**Signature of Retiree**

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Signature of Spouse**

\_\_\_\_\_  
Date