

MICHIGAN LABORERS' HEALTH CARE FUND RETIREE INFORMATION FORM

(TO BE COMPLETED BY DISABLED AND RETIRED PARTICIPANTS)

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

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