MICHIGAN LABORERS' HEALTH CARE FUND – Group 007004429

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

PLEASE PRINT **F77**

IMPORTANT: Please complete this form in its entirety, **listing all eligible dependents** (spouse and/or children) you wish to enroll in the Plan. **This form will replace any other enrollment form on file at the Administration Office. NOTE: If there is not enough room to list all dependents below, please list on a separate sheet of paper and attach. You must complete the reverse side of this form for all eligible adult dependent children age 19 - 25 years.**

Purpose For Completing Form: □ New Member □ Add Dependents □ Address Change □ Name Change_____ (previous name)

Name (Last, First, Middle Initial)	Social Security Number	Sex	Birthdate (Mo/Day/Year)	Relationship to Member	Check if Step, Foster or Adopted Child
Member				Self	
Mailing Address (Street, City, State, Zip Code)					
Phone Number	**Email Address**			**Local Union No.**	
Spouse*				**Date of Marriage**	
Dependent Children*					☐
					☐
					☐

***Important Note:** The Trust Fund requires documentation for each dependent you are enrolling, such as a copy of the birth certificate or proof of legal guardianship for each child, and a copy of the marriage certificate for your spouse. Failure to supply the required documentation may affect timely processing of your health care benefits. Do **not** send original certificates to the Administration Office. The Administration Office will not be responsible for returning original documents to Participants if submitted.

OTHER INSURANCE INFORMATION – **YOU MUST COMPLETE THIS SECTION**

1. Are you, your spouse, or other dependents covered by any other medical insurance including Medicare?
☐ Yes ☐ No If "yes", please provide the following information.

If covered by Medicare, please attach a copy of your Medicare ID card when returning this form to the Administration Office.

Name of Insured with Other Coverage | SS# or ID# | Policy or Group Number | Phone Number

Name and Address of other Insurance Company | City | State | Zip

2. Is this policy (choose one): ☐ Group ☐ Individual
3. Other Insurance Covers: ☐ Member ☐ Spouse ☐ Children

4. Are you, your spouse, or other dependents covered by any other dental insurance?
☐ Yes ☐ No If "yes", please provide the following information.

Name of Insured with Other Coverage | SS# or ID# | Policy or Group Number | Phone Number

Name and Address of other Insurance Company | City | State | Zip

5. Is this policy (choose one): ☐ Group ☐ Individual
6. Other Insurance Covers: ☐ Member ☐ Spouse ☐ Children

I hereby certify that the above information is true, correct, and complete to the best of my knowledge and belief. I understand that if I intentionally falsify any of the above information, 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. This form supersedes any enrollment signed prior to the date shown below.

Signature (*must be signed by participating employee*) Date

RETURN A COPY TO: ADMINISTRATION OFFICE, PO Box 211133, Eagan MN 55121-2533
or Scan and e-mail to: enrollment@wpas-inc.com or Fax to: (517) 689-6016
If you have any questions, please call 877-MI-LABOR (877-645-2267)
RETAIN A COPY FOR YOUR RECORDS

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MICHIGAN LABORERS' HEALTH CARE FUND
ADULT CHILD UNDER AGE 26

PLEASE LIST ALL ELIGIBLE ADULT DEPENDENT CHILD 19-25 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 _____ **Birthdate** _____

FAMILY CONTINUATION COVERAGE

Is your adult child under age 26 covered by any other medical insurance? This includes Medicare, Blue Criss Blue Shield, HMO Plans, PPO Plans, etc.
☐ 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 Insured with Other Coverage SS# or ID# Policy or Group Number Phone Number

Name and Address of other Insurance Company City State Zip

Family Members Covered Under the Policy

Name of Adult Child _____ Social Security Number _____

Complete Address of Adult Child _____ Birthdate _____

FAMILY CONTINUATION COVERAGE

Is your adult child under age 26 covered by any other medical insurance? This includes Medicare, Blue Criss Blue Shield, HMO Plans, PPO Plans, etc.
☐ 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 Insured with Other Coverage SS# or ID# Policy or Group Number Phone Number

Name and Address of other Insurance Company City State Zip

Family Members Covered Under the Policy

DEFINITION OF DEPENDENT ELIGIBILITY

Eligible dependents shall be the employee's legal spouse and children (including natural children, step-children, foster children, adopted children, and children placed with the employee or spouse for adoption, and/or eligible recipients under a Qualified Medical Support Order), up to 26 years of age. A child over age 26 who is currently mentally or physically disabled and that disability existed before the attainment of the Plan's age limit and is incapable of being self-supportive as a result of that disability; unmarried and dependent chiefly on You and/or Your Spouse for support and care.