MICHIGAN LABORERS' HEALTH CARE FUND

ENROLLMENT FORM

All participants **must** submit this completed Enrollment Form upon your initial eligibility for Fund benefits and resubmit this form when there is a change to your dependent status -- *i.e.*, marriage, birth, adoption, death or divorce. Failure to timely remit a completed form, including any of the required documentation listed under the Spouse/Dependent Information section, may cause a delay in processing your health care benefits.

Please return your completed Enrollment Form to:
6452 Millennium Dr, Suite 100, Lansing, Michigan 48917-7881 or
enrollment@wpas-inc.com

Participant Information

LastName	First Name	Middle Initial

Social Security Number	Date of Birth (MM/DD/YYYY)	Gender (Select One)
		☐ Male ☐ Female

Home and/or Cell Phone Number (include area code)	Email

Street Address	City	State	Zip

Marital Status (Select One)	Date of Marriage (if applicable)	Local Union Number
☐ Single ☐ Married ☐ Divorced		

Spouse/Dependent Information

The Fund requires the following documentation for your spouse and each dependent you are enrolling:

- a copy of the marriage certificate; and or
- a copy of the birth certificate or proof of legal guardianship for each child.

Do NOT send original certificates to the Fund Office. The Fund Office will not be held responsible for returning original documents to participants, if submitted.

Spouse/Dependent Name and Address	SSN	Relationship	Date of Birth	Gender (Select One)
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female

Participant Signature	Date

Addendum – Additional Dependents

Note: If you do not need to list additional dependents, skip this page, as it is not required.

Dependent Name and Address	SSN	Relationship	Date of Birth	Gender (Select One)
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female