PLUMBERS & PIPEFITTERS LOCAL 333 HEALTH & WELFARE RETIREE INFORMATION FORM

(TO BE COMPLETED BY DISABLED AND RETIRED PARTICIPANTS)

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.

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

Are you enrolled in Medicare D? ___________NO _________YES

Are you enrolled in any Medicare Advantage Program? ____________NO _________YES

If you do not have Medicare – are you "eligible" to enroll in Medicare? ______NO ___YES

If you are enrolled in Medicare, please provide the following information:

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▲

Marital Status __SINGLE __MARRIED __WIDOWED __DIVORCED __SEPARATED

THE FOLLOWING INFORMATION PERTAINS TO YOUR SPOUSE:

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 the Social Security Disability Award along with this form

Is your spouse enrolled in Medicare D? ____________NO _________YES

Is your spouse enrolled in any Medicare Advantage Program? ______NO _________YES

If your spouse does not have Medicare – is he/she "eligible" to enroll in Medicare?
______NO ______YES

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If your spouse is enrolled in Medicare, please provide the following information:

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▲

Do you have any eligible dependent children that should be covered under the Plumbers & Pipefitters Local 333 Health & Welfare 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:

Plumbers & Pipefitters Local 333 Health & Welfare
6525 Centurion Drive
Lansing, MI 48917
(866) 348-9499