PLUMBERS' & PIPEFITTERS' LOCAL NO. 333 HEALTH & WELFARE FUND

Managed for the Trustees by: TIC INTERNATIONAL CORPORATION

HEALTH CARE (BCBSM) ENROLLMENT FORM AND

YEARLY COORDINATION OF BENEFITS AND DEPENDENT STATUS STATEMENT

(Please Type or Print Clearly)

	/		/	/			
Participant's Name	Birth Date	Me	ember ID (MID) OR SS	# Te	elephone Number		
Address:							
Check if new							
MARITAL STATUS (Check One):	Married	Single	Divorced	Widow	Separated		
Spouse's Name	Birthdate			Social Secu	Social Security No.		
Dependent's Name	Relationship Birthdate			Social Security No.			
					_		
-NOTE: PLEASE L			JATION COVERAGE	THE REVERSE S	DIDE OF THIS FORM-		
Are you or your dependents covered includes Medicare, Blue Cross Blue S	by any other medic Shield, HMO Plans,	al insurance, for ex PPO Plans, etc.	xample insurance cove	rage from their e	mployer or their spouse? This		
Check One Yes No	If Yes, please c	complete the sectio	n below:				
Is this policy (Check One)	Group	Individual					
Name of Other Insurance				Telephone r	number		
Address of Other Insurance							
Policy Number			Group	Number			
Policyholder's Name			Effect	ive Date of Cove	rage		
Family Members Covered under the	Policy						
		1 : for					
Are you or your dependents covered Check One Yes No		complete the sectio		ige nom their en	ipioyer of their spouse?		
Is this policy (Check One)	Group	Individual	n below.				
	Croup	mainauai					
Name of Other Insurance				Telephone r	number		
Address of Other Insurance							
Policy Number			Group	Number			
Policyholder's Name			Effect	ive Date of Cove	erage		
Family Members Covered under the	Policy						
	PI F/	ASE READ CAREE	TULLY AND SIGN BEI	OW			
PLEASE READ CAREFULLY AND SIGN BELOW I hereby certify that the above statements are true and complete to the best of my knowledge and belief. I understand that if I intentionally falsify any of the above information, the Fund may deny claims, coverage may be terminated, 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.							
Member's Signature:				D	ate:		
Spouse's Signature:				D	ate:		

Return this form to: PLUMBERS & PIPFITTERS' LOCAL NO. 333 HEALTH & WELFARE FUND 6525 CENTURION DR, LANSING MI 48917

PLUMBERS' & PIPEFITTERS' LOCAL NO. 333 HEALTH & WELFARE FUND ADULT CHILD UNDER AGE 26

PLEASE LIST ALL ELIGIBLE ADULT DEPENDENT CHLDREN UNDER AGE 26 BELOW

(If you have more than two adult children under age 26, please use a separate sheet of paper)

In accordance with the Patient Protection and Affordable Care Act (PPACA), the Fund provides coverage for dependent children through the last day of the month in which the child turns age 26. Dependents qualify whether they are married or unmarried and are eligible for coverage even if they are covered by a policy from their employer or spouse. However, in these instances, the Fund may coordinate coverage with such other policies.

NAME OF ADULT CHILD COMPLETE ADDRESS OF ADULT CHILD			SOCIAL SECURITY NUMBER				
Is your adult child under age 26 covered includes Medicare, Blue Cross Blue Shie	by any other medical insurance, for example Id, HMO Plans, PPO Plans, etc.	insurance co	overage from their e	employer or thei	r spouse? This		
Check One Yes No	If Yes, please complete the sec	ction below:					
Is your adult child eligible to enroll in in h	ealth care coverage other than this Plan?	Yes	No				
If yes, is your adult child enrolled in in he	alth care coverage other than this Plan?	Yes	No				
	If Yes, please complete the se	ction below:					
Effective date of other medical insurance	:	Is this polic	cy (check one)	Group	Individual		
Name of Other Insurance			Telephone num	ber			
Address of Other Insurance							
Policy Number Group Number		Policy	nolder's Name				
Family Members Covered under the Poli	cv						
NAME OF ADULT CHILD		SOCIA	L SECURITY NUM	IBER			
NAME OF ADULT CHILD	LD	SOCIA		IBER			
	ILD FAMILY CONTINUATION CO	BIRTH		IBER			
COMPLETE ADDRESS OF ADULT CH	FAMILY CONTINUATION Co	BIRTH OVERAGE	DATE		spouse?? This		
COMPLETE ADDRESS OF ADULT CH	FAMILY CONTINUATION Co	BIRTH OVERAGE insurance co	DATE		spouse?? This		
COMPLETE ADDRESS OF ADULT CHI Is your adult child under age 26 covered includes Medicare, Blue Cross Blue Shie Check One Yes No	FAMILY CONTINUATION Control by any other medical insurance for example old, HMO Plans, PPO Plans, etc.	BIRTH OVERAGE insurance co	DATE		spouse?? This		
COMPLETE ADDRESS OF ADULT CHI Is your adult child under age 26 covered includes Medicare, Blue Cross Blue Shie Check One Yes No	FAMILY CONTINUATION Co by any other medical insurance for example ld, HMO Plans, PPO Plans, etc. If Yes, please complete the sec ealth care coverage other than this Plan ?	BIRTH OVERAGE insurance con	DATE verage from their e		spouse?? This		
COMPLETE ADDRESS OF ADULT CHI Is your adult child under age 26 covered includes Medicare, Blue Cross Blue Shie Check One Yes No Is your adult child eligible to enroll in in h	FAMILY CONTINUATION Co by any other medical insurance for example ld, HMO Plans, PPO Plans, etc. If Yes, please complete the sec ealth care coverage other than this Plan ?	BIRTH OVERAGE insurance cor ction below: Yes Yes	DATE verage from their e No		spouse?? This		
COMPLETE ADDRESS OF ADULT CHI Is your adult child under age 26 covered includes Medicare, Blue Cross Blue Shie Check One Yes No Is your adult child eligible to enroll in in h	FAMILY CONTINUATION Co by any other medical insurance for example eld, HMO Plans, PPO Plans, etc. If Yes, please complete the sec ealth care coverage other than this Plan ? If Yes, please complete the sec	BIRTH OVERAGE insurance co ction below: Yes Yes ction below:	DATE verage from their e No		spouse?? This		
COMPLETE ADDRESS OF ADULT CHI Is your adult child under age 26 covered includes Medicare, Blue Cross Blue Shie Check One Yes No Is your adult child eligible to enroll in in h If yes, is your adult child enrolled in healt	FAMILY CONTINUATION Co by any other medical insurance for example eld, HMO Plans, PPO Plans, etc. If Yes, please complete the sec ealth care coverage other than this Plan ? If Yes, please complete the sec	BIRTH OVERAGE insurance co ction below: Yes Yes ction below:	DATE verage from their e No No	mployer or their Group			
COMPLETE ADDRESS OF ADULT CHI Is your adult child under age 26 covered includes Medicare, Blue Cross Blue Shie Check One Yes No Is your adult child eligible to enroll in in h If yes, is your adult child enrolled in healt Effective date of other medical insurance	FAMILY CONTINUATION Co by any other medical insurance for example eld, HMO Plans, PPO Plans, etc. If Yes, please complete the sec ealth care coverage other than this Plan ? If Yes, please complete the sec	BIRTH OVERAGE insurance co ction below: Yes Yes ction below:	DATE verage from their e No No cy (check one)	mployer or their Group			
COMPLETE ADDRESS OF ADULT CHI Is your adult child under age 26 covered includes Medicare, Blue Cross Blue Shie Check One Yes No Is your adult child eligible to enroll in in h If yes, is your adult child enrolled in healt Effective date of other medical insurance Name of Other Insurance	FAMILY CONTINUATION Co by any other medical insurance for example eld, HMO Plans, PPO Plans, etc. If Yes, please complete the sec ealth care coverage other than this Plan ? If Yes, please complete the sec	BIRTH OVERAGE insurance co ction below: Yes Yes ction below: Is this polic	DATE verage from their e No No cy (check one)	mployer or their Group			