# 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 | Member ID (MID) OR SS# | Telephone Number |

Address: ☐ Check if new

**MARITAL STATUS** (Check One): ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Separated

Spouse's Name | Birthdate | Social Security No.

| Dependent's Name | Relationship | Birthdate | Social Security No. |
|---|---|---|---|
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**FAMILY CONTINUATION COVERAGE**

**-NOTE: PLEASE LIST ALL ELIGIBLE ADULT DEPENDENT UNDER AGE 26 ON THE REVERSE SIDE OF THIS FORM-**

Are you or your dependents covered by any other medical insurance, for example insurance coverage from their employer or their spouse? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.

Check One ☐ Yes ☐ No If Yes, please complete the section below:

Is this policy (Check One) ☐ Group ☐ Individual

Name of Other Insurance | Telephone number

Address of Other Insurance

Policy Number | Group Number

Policyholder's Name | Effective Date of Coverage

Family Members Covered under the Policy

Are you or your dependents covered by any other dental insurance, for example insurance coverage from their employer or their spouse?

Check One ☐ Yes ☐ No If Yes, please complete the section below:

Is this policy (Check One) ☐ Group ☐ Individual

Name of Other Insurance | Telephone number

Address of Other Insurance

Policy Number | Group Number

Policyholder's Name | Effective Date of Coverage

Family Members Covered under the Policy

**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:** **Date:**

**Spouse's Signature:** **Date:**

**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** | **SOCIAL SECURITY NUMBER**

**COMPLETE ADDRESS OF ADULT CHILD** | **BIRTH DATE**

**FAMILY CONTINUATION COVERAGE**

Is your adult child under age 26 covered by any other medical insurance, for example insurance coverage from their employer or their spouse? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.

Check One ☐ Yes ☐ No If Yes, please complete the section below:

Is your adult child eligible to enroll in in health care coverage other than this Plan ? ☐ Yes ☐ No

If yes, is your adult child enrolled in in health care coverage other than this Plan ? ☐ Yes ☐ No

If Yes, please complete the section below:

Effective date of other medical insurance:_____ Is this policy (check one) ☐ Group ☐ Individual

Name of Other Insurance | Telephone number

Address of Other Insurance

Policy Number | Group Number | Policyholder's Name

Family Members Covered under the Policy

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**NAME OF ADULT CHILD** | **SOCIAL SECURITY NUMBER**

**COMPLETE ADDRESS OF ADULT CHILD** | **BIRTH DATE**

**FAMILY CONTINUATION COVERAGE**

Is your adult child under age 26 covered by any other medical insurance for example insurance coverage from their employer or their spouse?? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.

Check One ☐ Yes ☐ No If Yes, please complete the section below:

Is your adult child eligible to enroll in in health care coverage other than this Plan ? ☐ Yes ☐ No

If yes, is your adult child enrolled in health care coverage other than this Plan? ☐ Yes ☐ No

If Yes, please complete the section below:

Effective date of other medical insurance:_____ Is this policy (check one) ☐ Group ☐ Individual

Name of Other Insurance | Telephone number

Address of Other Insurance

Policy Number | Group Number | Policyholder's Name

Family Members Covered under the Policy