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.

IBEW LOCAL NO. 1392 HEALTH & WELFARE FUND
RETIREE INFORMATION FORM

(TO BE COMPLETED BY DISABLED AND RETIRED PARTICIPANTS)

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

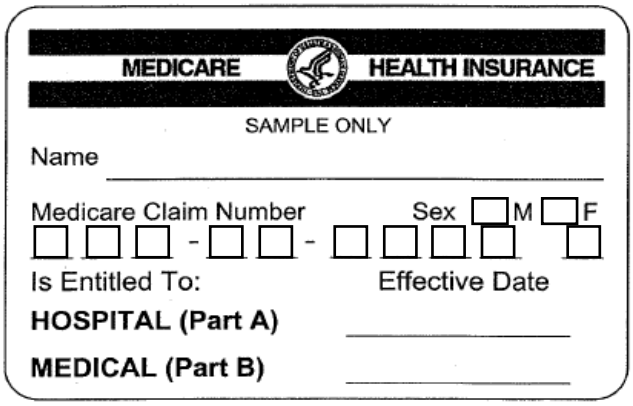
Please take out your Medicare card to complete this section.

- 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



▲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

-over-

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

Please provide your Medicare insurance information

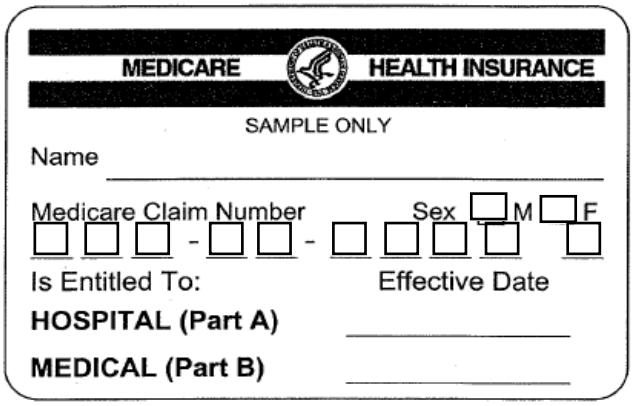
Please take out your Medicare card to complete this section.

- 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



▲This is for your SPOUSE'S Medicare Information▲

Do you have any eligible dependent children that should be covered under the Michigan Carpenters' 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:

IBEW Local No. 1392 Health & Welfare Fund
6525 Centurion Drive
Lansing, MI 48917
(833) 336-1392