IBEW LOCAL 1392 HEALTH & WELFARE FUND

Managed for the Trustees by: TIC INTERNATIONAL CORPORATION

HEALTH CARE ENROLLMENT FORM AND
YEARLY COORDINATION OF BENEFITS AND DEPENDENT STATUS STATEMENT

NOTE: THIS FORM MUST BE COMPLETED IN ORDER TO BE ELIGIBILE FOR BENEFITS. IF IT IS NOT COMPLETED, YOU AND YOUR DEPENDENTS WILL NOT BE ELIGIBLE FOR BENEFITS UNDER THIS PLAN

	/	/	/
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 | Birth Date | Social Security No.

Dependent's Name	Relationship	Birth Date	Social Security No.

FAMILY CONTINUATION COVERAGE
-NOTE: PLEASE LIST ALL ELIGIBLE ADULT DEPENDENT CHLDREN 19-26 ON THE REVERSE SIDE OF THIS FORM-

Are you or your dependents covered by any other medical insurance? 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?

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, Medical claims may be denied and I may be subject to the Federal False Claims Act and 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: IBEW Local 1392 Health & Welfare Fund, 6525 Centurion Drive, Lansing MI 48917

IBEW LOCAL 1392 HEALTH & WELFARE FUND

ADULT CHILD UNDER AGE 26

PLEASE LIST ALL ELIGIBLE ADULT DEPENDENT CHILDREN 19-26 BELOW

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

The Health Care and Education Affordability Reconciliation Act of 2010 requires the Fund to extend dependent child coverage up to age 26. Dependents qualify whether they are married or unmarried. However, if your dependent has another offer of employer-based coverage (such as through his or her job) they are not eligible to enroll under this Plan.

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? 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 employer-based coverage? ☐ Yes ☐ No

If yes, is your adult child enrolled in employer-based coverage? ☐ 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

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? 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 employer-based coverage? ☐ Yes ☐ No

If yes, is your adult child enrolled in employer-based coverage? ☐ 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