# PLUMBERS AND PIPEFITTERS LOCAL NO. 172 WELFARE FUND

Managed for the Trustees by: TIC INTERNATIONAL CORPORATION

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

(Please Type or Print Clearly)

Participant's Name | Birthdate: | Member ID or SSN | 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.

**PLEASE LIST ALL ELIGIBLE ADULT DEPENDENT CHLDREN AGE 19-26**
**FOR ADDITIONAL SPACE USE THE REVERSE SIDE OF THIS FORM**

### FAMILY CONTINUATION COVERAGE

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 | Effective Date

Policy Number | Group Number | Policyholder's Name

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 | Effective Date

Policy Number | Group Number | Policyholder's Name

Family Members Covered under the Policy

Are you or your dependents covered by any other **vision 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 | Effective Date

Policy Number | Group Number | Policyholder's Name

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 litigation by the Fund. I also understand that I must notify the Fund of any changes in the above information within 30 days of any change.**

**Member's Signature:** **Date:**

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

**Return this form to:**
**PLUMBERS AND PIPEFITTERS LOCAL NO. 172 WELFARE FUND, 6525 Centurion Drive, Lansing MI 48917**

# PLUMBERS AND PIPEFITTERS LOCAL NO. 172 WELFARE FUND

## DEPENDENT STATUS STATEMENT – ADULT CHILD UNDER AGE 26

## PLEASE LIST ALL ELIGIBLE ADULT DEPENDENT CHLDREN AGE 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. If your dependent has another offer of employer-based coverage (such as through his or her job) they are still eligible to enroll under this Plan. However, if your dependent is enrolled in this Plan and also receives coverage under another plan, this Plan will coordinate benefits with the other plan pursuant to terms of the Plan Document.

**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