LABORERS METROPOLITAN DETROIT HEALTH CARE FUND

Managed for the Trustees by: TIC MIDWEST

REQUEST FOR EXTENSION OF COVERAGE FOR AN ADULT CHILD UNDER AGE 26

(Please Type or Print Clearly)

Participant's Name	Birth Date	Member ID (MID) OR SS#	Telephone Number

Participant's Address:______________________________________

Street City State Zip

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

Spouse's Name	Birth date	Social Security No.

Dependent's Name (List All)	Relationship	Birth date	Social Security No.

ADULT CHILD UNDER AGE 26 FOR WHICH THE EXTENSION OF COVERAGE IS REQUESTED

(If more than one such adult child, please use the reverse side of this form.)

EFFECTIVE DATE FOR THE ADULT CHILD'S COVERAGE WILL BE THE FIRST OF THE MONTH FOLLOWING RECEIPT OF THIS FORM

______________________________ ______________________________

NAME OF ADULT CHILD **SOCIAL SECURITY NUMBER**

______________________________ ______________________________

ADDRESS OF ADULT CHILD **BIRTH DATE**

FAMILY CONTINUATION COVERAGE

Does your adult child work for an employer who provides/would provide health care benefits? Check One Yes No

Are you, your dependents or adult child(ren) 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:

Effective date of other medical insurance:_____________________________ Is this policy (check one) Group or Individual ?

Name of Other Insurance		Telephone number
Address of Other Insurance		Fax Number
Policy Number	Group Number	Policyholder's Name
Family Members Covered under the Policy		

PLEASE READ CAREFULLY AND SIGN BELOW

I have read the information describing the special enrollment opportunity for adult children and understand the participation conditions and requirements. By signing below, I certify that: 1) the information provided above is correct; 2) All adult child coverage is contingent upon me maintaining my eligibility under the Plan; 3) I will be financially responsible for any claims paid for ineligible adult children if the claims were paid based upon inaccurate or misleading information I provide. 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:

LABORERS' METROPOLITAN DETROIT HEALTH CARE FUND
6525 Centurion Drive, Lansing MI 48917

(OVER)

LABORERS' METROPOLITAN DETROIT HEALTH CARE FUND
ADULT CHILD UNDER AGE 26 FOR WHICH THE EXTENSION OF COVERAGE IS REQUESTED
(If more than one such adult child, please use this side of this form.)

PARTICPANT'S NAME ______________________ **MEMBER ID (MID) OR SS NUMBER** ______________________

EFFECTIVE DATE FOR THE ADULT CHILD'S COVERAGE WILL BE THE FIRST MONTH FOLLOWING RECEIPT OF THIS FORM.

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

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

Does your adult child work for an employer who provides/would provide health care benefits? Check One Yes No

Are you, your dependents or adult child(ren) 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:

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Address of Other Insurance		Fax Number
Policy Number	Group Number	Policyholder's Name
Family Members Covered under the Policy		

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

ADDRESS OF ADULT CHILD ______________________ **BIRTH DATE** ______________________

Does your adult child work for an employer who provides/would provide health care benefits? Check One Yes No

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Address of Other Insurance		Fax Number
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Family Members Covered under the Policy		