LABORERS MEETROPOLITAN DETROIT HEALTH CARE FUND

Managed for the Trustees by: TIC INTERNATIONAL CORPORATION

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:

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

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