LABORERS' METROPOLITAN DETROIT HEALTH CARE FUND

Managed for the Trustees by: TIC INTERNATIONAL CORPORATION

YEARLY COORDINATION OF BENEFITS AND DEPENDENT STATUS STATEMENT

(Please Type or Print Clearly)

Participant's Name **Birth Date** **Member ID or SS#** **Telephone Number**

Address:

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 DEPENDENT CHILDREN AGES 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 Effective Date Telephone number

Address of Other Insurance

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 Effective Date Telephone number

Address of Other Insurance

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 Effective Date Telephone number

Address of Other Insurance

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: Laborers' Metropolitan Detroit Health Care Fund, 6525 Centurion Drive, Lansing MI 48917

LABORERS' METROPOLITAN DETROIT HEALTH CARE FUND
PLEASE LIST ALL ELIGIBLE ADULT DEPENDENT CHLDREN 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. As of January 1, 2013, 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.

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 Effective Date

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 Effective Date

Policy Number Group Number Policyholder's Name

Family Members Covered under the Policy