MICHIANA AREA ELECTRICAL WORKERS' HEALTH & WELFARE FUND

Managed for the Trustees by: TIC INTERNATIONAL CORPORATION

HEALTH CARE ENROLLMENT FORM & YEARLY COORDINATION OF BENEFITS AND DEPENDENT STATUS STATEMENT CALENDAR YEAR 2024

(Please Type or Print Clearly)

Participant's Name **Birthdate:** **Member ID or SS#** **Telephone number**

Address: **City:** **State:** **Zip:**

Member Email Address

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

Spouse's Name Birthdate Social Security No.

Spouse Email Spouse Telephone Number:

Dependent's Name Relationship Birthdate Social Security No.

FAMILY CONTINUATION COVERAGE

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

PLEASE NOTE: YOU ARE REQUIRED TO COMPLETE AND RETURN THE SPOUSE EMPLOYMENT INFORMATION FORM REGARDLESS OF YOUR MARITAL STATUS OR YOUR SPOUSE'S EMPLOYMENT STATUS

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 and submit a copy of the front & back of your card:

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

Are you or your dependents covered by any other dental insurance?
Check One ☐ Yes ☐ No If Yes, please complete the section below and submit a copy of the front & back of your card:

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

Are you or your dependents covered by any other vision insurance?
Check One ☐ Yes ☐ No If Yes, please complete the section below and submit a copy of the front & back of your card:

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

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: Michiana Area Electrical Workers' H&W Fund, 6525 Centurion Drive, Lansing MI 48917

MICHIANA AREA ELECTRICAL WORKERS' HEALTH & WELFARE FUND

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

(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. Dependents are still eligible under the Plan until they reach age 26.

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

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

FAMILY CONTINUATION COVERAGE

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 ☐ 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

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 ☐ Individual

Name of Other Insurance _____ 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 have read and understand the participation conditions and requirements for adult dependent children up to age 26. 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:** _____