MICHIGAN CARPENTERS' HEALTH CARE FUND

Managed for the Trustees by: TIC MIDWEST

YEARLY COORDINATION OF BENEFITS AND DEPENDENT STATUS STATEMENT

(Please Type or Print Clearly)

/ / /

Participant's Name	Birth Date	SSN	Telephone Number

Address:

Check if new

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

Spouse's Name	Birthdate	Social Security No.

List all Dependent(s) Name(s)	Relationship	Birthdate	Social Security No.

Are you, your spouse and/or dependents (up to age 26) covered by another health care plan? Yes No

If No, please sign the form.

If Yes, please complete the Yearly Coordination of Benefits below and sign the form.

YEARLY COORDINATION OF BENEFITS

Is this policy (Check One) Group Individual Medical Prescription Dental Other

Policy Number Group number

Policyholder's Name Effective Date of Coverage

Name of Other Insurance Telephone number

Address of Other Insurance

Family Members Covered under the Policy

Is this policy (Check One) Group Individual Medical Prescription Dental Other

Policy Number Group number

Policyholder's Name Effective Date of Coverage

Name of Other Insurance Telephone number

Address of Other Insurance

Family Members Covered under the Policy

If needed, please add an additional sheet of paper and check this box.

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 information on this form within 30 days of any change.

Member's Signature: **Date:**

Spouse's Signature: **Date:**

Return this form to: Michigan Carpenters' Health Care Fund, 6525 Centurion Drive, Lansing MI 48917