MICHIGAN CARPENTERS' HEALTH CARE FUND
RETIREE ELECTION FORM – DENTAL

I have read and understand the provisions for continuing under the Plan. I have checked the type of coverage that I am eligible for. **I understand that my election of dental coverage is a one (1) time election and that I cannot add or cancel dental benefits without writing to the Board of Trustees.**

It is the intent of the Board of Trustees to review these rates and make appropriate adjustments on a regular basis.

NAME: _____

Member ID or SS#: _____ Date of Birth: _____ Local Union #: _____

MARITAL STATUS - ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

SPOUSE'S NAME: _____

SPOUSE'S SS#: _____ DATE OF BIRTH: _____

Do you have any eligible dependent children that should be covered by this plan? YES ☐ NO ☐

If "YES," state full name of dependent, relationship, date of birth and social security number.:

Name of Dependent	Relationship	Date of Birth	Social Security Number

If any of the above information changes, it is your responsibility to immediately contact the Fund Office.

Please Indicate Type of Coverage Elected (Please note: If you currently have family or 2 person coverage, you cannot elect member only dental coverage.)

☐ **SINGLE:** DENTAL BENEFITS – ADDITIONAL $5.95 PER MONTH

☐ **TWO PERSON:** DENTAL BENEFITS – ADDITIONAL $14.29 PER MONTH

☐ **FAMILY:** DENTAL BENEFITS – ADDITIONAL $17.86 PER MONTH

I certify that the above information is true and complete to the best of my knowledge.

_____

Signature of Retiree Date

_____

Signature of Spouse Date