

MICHIGAN CARPENTERS' HEALTH CARE FUND

Managed for the Trustees by: TIC INTERNATIONAL CORPORATION

YEARLY COORDINATION OF BENEFITS AND DEPENDENT STATUS STATEMENT FOR _____

(PLEASE TYPE OR PRINT CLEARLY)

PARTICIPANT'S NAME:			BIRTH DATE:
HOME ADDRESS (STREET NAME AND ADDRESS):		STATE:	ZIP CODE:
SEX:	SOCIAL SECURITY No.:	LOCAL UNION No.:	TELEPHONE NUMBER:

MARITAL STATUS (Circle One): Married Single Divorced Widowed Separated

SPOUSE'S NAME:	BIRTH DATE:	SOCIAL SECURITY No.:
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DEPENDENT'S NAME:	BIRTH DATE:	RELATIONSHIP:
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Are you or your dependents covered by any other medical insurance? This includes Medicare, Blue Cross-Blue Shield, HMO plans, PPO plans, etc.

Circle One: Yes No If Yes, please complete the section below:

Is this policy (Circle One): Group Individual

NAME OF OTHER INSURANCE:	TELEPHONE NUMBER: ()
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ADDRESS OF OTHER INSURANCE:

POLICY NUMBER:	GROUP NUMBER:	POLICYHOLDER'S NAME:
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FAMILY MEMBERS COVERED UNDER THE POLICY:

*SPOUSE'S EMPLOYER:	DATE EMPLOYED:
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*SPOUSE'S EMPLOYER'S ADDRESS:

***PLEASE NOTE: IF SPOUSE IS EMPLOYED AND YOU HAVE INDICATED THAT SPOUSE HAS NO OTHER INSURANCE COVERAGE, PLEASE HAVE SPOUSE'S EMPLOYER COMPLETE REVERSE SIDE OF THIS FORM.**

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 _____

****This form must be completed in detail once each year to avoid delay in the processing of your claims.**



MICHIGAN CARPENTERS' HEALTH CARE FUND

6525 Centurion Drive
Lansing, MI 48917-9275

800-273-5739

Phone: (517) 321-7502 Fax: (517) 321-7508

Due to the fact that your spouse is employed and may have other group health coverage (that you may not be aware of), it is necessary for your spouse's employer to complete the bottom portion of this form.

Payment of pending and/or future claims will be considered upon receipt of this completed form.

Member's Name: _____

Member's Social Security No.: _____ Local Union No.: _____

Spouse's Name: _____ Spouse's Soc. Sec. No.: _____

THIS PORTION MUST BE COMPLETED BY SPOUSE'S EMPLOYER

(PLEASE TYPE OR PRINT)

Do you cover _____ with group health coverage? Yes No

If yes, please indicate the effective date: _____

If coverage has been terminated, please indicate date: _____

Please indicate Carrier's Name: _____

Carrier's Address: _____

Carrier's Telephone No.: _____

If no insurance coverage is provided, please indicate reason: _____

Name of Employer: _____

Address: _____

Telephone No.: _____

Signature of Person Completing Form: _____

Title: _____ Date: _____