

# UP PLUMBERS' & PIPEFITTERS HEALTH AND WELFARE FUND

Managed for the Trustees by : TIC INTERNATIONAL CORPORATION

## YEARLY COORDINATION OF BENEFITS AND DEPENDENT STATUS STATEMENT FOR 2006

(Please Type or Print Clearly)

Participant's Name \_\_\_\_\_ Social Security Number \_\_\_\_\_ Telephone number \_\_\_\_\_

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

Spouse's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security No. \_\_\_\_\_

Dependent's Name \_\_\_\_\_ Relationship \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security No. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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 \_\_\_\_\_

Address of Other Insurance \_\_\_\_\_ Phone Number \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_ Policyholder's Name \_\_\_\_\_

Family Members Covered under the Policy \_\_\_\_\_

\_\_\_\_\_

Are you or your dependents covered by any other dental insurance.

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

Is this policy (Circle 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.

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

Is this policy (Circle 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: \_\_\_\_\_

Please complete reverse side

**UP PLUMBERS' & PIPEFITTERS HEALTH AND WELFARE FUND**

6525 Centurion Drive

Lansing, MI 48917

Name (Please Print): \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Local Union Number: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Soc. Sec. No: \_\_\_\_\_

**THIS PORTION MUST BE COMPLETED BY SPOUSE'S EMPLOYER**

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 number: \_\_\_\_\_

Signature of Person Completing Form \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_