

**UPPER PENINSULA PLUMBERS' AND PIPEFITTERS
HEALTH & WELFARE FUND**

RETIREE INFORMATION FORM

(TO BE COMPLETED BY DISABLED AND / OR RETIRED PARTICIPANTS)

Name _____

SS# _____ Date of Birth _____ Local _____

Do you have a **SOCIAL SECURITY DISABILITY AWARD**? ___ NO ___ YES

Do you have part **A** and **B** of **MEDICARE**? ___ NO ___ YES

Marital Status ___ SINGLE ___ MARRIED ___ WIDOWED ___ DIVORCED ___ SEPARATED

Spouse's Name _____

Spouse's SS# _____ Spouse's Date of Birth _____

Does your **Spouse** have a **SOCIAL SECURITY DISABILITY AWARD**? ___ NO ___ YES

Does your **Spouse** have part **A** and **B** of **MEDICARE**? ___ NO ___ YES

Do you have any eligible dependent children that should be covered under the UP Plumbers' and Pipefitters' Health & Welfare Fund ___ NO ___ YES

IF "YES", STATE FULL NAME OF DEPENDENT AND DATE OF BIRTH

If any of the children listed above have **MEDICARE**, please indicate which child and their **MEDICARE EFFECTIVE DATE**. **PLEASE SEND A COPY OF THEIR MEDICARE CARD WITH THIS COMPLETED FORM.**

IF ANY OF THE ABOVE INFORMATION CHANGES, IT IS YOUR RESPONSIBILITY TO CONTACT THE FUND OFFICE, IMMEDIATELY.

I/WE CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE AND BELIEF.

Date

Signature of Participant

Date

Signature of Spouse

If you, your spouse, or any eligible dependent children have Medicare or a Social Security Disability Award please forward a copy to the Fund office.