

**UPPER PENINSULA PLUMBERS' & PIPEFITTERS'**

**TOTALLY & PERMANENTLY DISABLED INFORMATION FORM**

NAME \_\_\_\_\_

SS# \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ LOCAL UNION # \_\_\_\_\_

DO YOU HAVE A SOCIAL SECURITY DISABILITY AWARD? YES \_\_\_ NO \_\_\_

DO YOU HAVE PART A AND B OF MEDICARE? YES \_\_\_ NO \_\_\_

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? YES \_\_\_ NO \_\_\_

DOES YOUR SPOUSE HAVE PART A AND B OF MEDICARE ? YES \_\_\_ NO \_\_\_

DO YOU HAVE ANY ELIGIBLE DEPENDENT CHILDREN THAT SHOULD BE COVERED BY THIS PLAN? YES \_\_\_ NO \_\_\_

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

\_\_\_\_\_

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

**PLEASE INDICATE TYPE OF COVERAGE ELECTED**

\_\_\_ **HEALTH CARE MEMBER ONLY - \$213.00 PER MONTH**

\_\_\_ **HEALTH CARE - FAMILY - \$475.00 PER MONTH**

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

SIGNATURE OF RETIREE \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE OF SPOUSE \_\_\_\_\_ DATE \_\_\_\_\_