# FLINT PLUMBING & PIPEFITTING INDUSTRY INSURANCE FUND
# GROUP 007003760

Managed for the Trustees by : TIC INTERNATIONAL CORPORATION

## HEALTH CARE (BCBSM) ENROLLMENT FORM &
## YEARLY COORDINATION OF BENEFITS AND DEPENDENT STATUS STATEMENT

(Please Type or Print Clearly)

Please print (First, Middle, & Last Names, as applicable) Birthdate:(NN/NN/NNNN format) Member ID or SSN (NNN-NN-NNNN format) Telephone (NNN-NNN-NNNN)

Address:

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

Spouse's Name Birthdate Social Security No.

Dependent's Name Relationship Birthdate Social Security No.

**FAMILY CONTINUATION COVERAGE**

**-NOTE: PLEASE LIST ALL ELIGIBLE ADULT DEPENDENT CHLDREN 19-26 ON THE REVERSE SIDE OF THIS FORM-**

Are you or your dependents covered by any other medical insurance. This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.
Check One ☐ Yes ☐ No If Yes, please complete the section below:
Is this policy (Check 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 dental insurance.
Check One ☐ Yes ☐ No If Yes, please complete the section below:
Is this policy (Check 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.
Check One ☐ Yes ☐ No If Yes, please complete the section below:
Is this policy (Check 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:**

**Return this form to: Flint Plumbing & Pipefitting Industry Insurance Fund, 6525 Centurion Drive, Lansing MI 48917**

# FLINT PLUMBING & PIPEFITTING INDUSTRY INSURANCE FUND

## ADULT CHILD UNDER AGE 26

## PLEASE LIST ALL ELIGIBLE ADULT DEPENDENT CHLDREN 19-26 BELOW

**(If you have more than two adult children under age 26, please use a separate sheet of paper)**

The Health Care and Education Affordability Reconciliation Act of 2010 requires the Fund to extend dependent child coverage up to age 26. Dependents qualify whether they are married or unmarried. Even if your dependent has employer-based coverage through his or her job they are eligible to enroll under this Plan – however their employer based Plan will be primary.

**NAME OF ADULT CHILD** _____ **SOCIAL SECURITY NUMBER** _____

**COMPLETE ADDRESS OF ADULT CHILD** _____ **BIRTH DATE** _____

**FAMILY CONTINUATION COVERAGE**

Is your adult child under age 26 covered by any other medical insurance? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.

Check One ☐ Yes ☐ No If Yes, please complete the section below:

Is your adult child ***eligible to enroll*** in employer-based coverage? ☐ Yes ☐ No

If yes, is your adult child enrolled in employer-based coverage? ☐ Yes ☐ No

If Yes, please complete the section below

Effective date of other medical insurance:_____ Is this policy (check one) ☐ Group or ☐ Individual?

Name of Other Insurance _____ Telephone number _____

Address of Other Insurance _____

Policy Number _____ Group Number _____ Policyholder's Name _____

Family Members Covered under the Policy _____

**NAME OF ADULT CHILD** _____ **SOCIAL SECURITY NUMBER** _____

**COMPLETE ADDRESS OF ADULT CHILD** _____ **BIRTH DATE** _____

**FAMILY CONTINUATION COVERAGE**

Is your adult child under age 26 covered by any other medical insurance? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.

Check One ☐ Yes ☐ No If Yes, please complete the section below:

Is your adult child ***eligible to enroll*** in employer-based coverage? ☐ Yes ☐ No

If yes, is your adult child enrolled in employer-based coverage? ☐ Yes ☐ No

If Yes, please complete the section below

Effective date of other medical insurance:_____ Is this policy (check one) ☐ Group or ☐ Individual?

Name of Other Insurance _____ Telephone number _____

Address of Other Insurance _____

Policy Number _____ Group Number _____ Policyholder's Name _____

Family Members Covered under the Policy _____