Abatement Workers National Health & Welfare Fund

P.O. BOX 1349
Troy, MI 48099-1349
(248) 641-4907 or (800) 772-0459

VITAL INFORMATION FORM

MEMBER Information: *(Please Print)*

Last: _____ First: _____ Middle: _____

Address/City/State/Zip:_____

Social Security Number: _____-_____-_____ Telephone Number: (_____)_____

Date of Birth: _____/_____/_____ Gender: (*circle one*) Male Female

Marital Status: *(circle one*) Single Married Divorced Separated Widowed
Date of Marriage/Divorce/Separation: _____

Current Status: *(circle one)* Active Retired (date retired_____) Disabled COBRA

Medicare Claim Number: (including the letter(s) that follows the number)
(This only applies when a member, a spouse, or a covered dependent is age 65 or older or on Medicare disability)

Member # _____ Spouse # _____ Dependent # and Name _____

DEPENDENTS: - Include Spouse (If additional space is needed, please use 2nd sheet)

FULL NAME	RELATION	BIRTH DATE	SOCIAL SECURITY NUMBER
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

***Student Certification for each dependent child over age 19 must be sent to the Benefit Office each semester. Coverage will terminate if Student Certification is not received.*

BENEFICIARY(ies): (Death Benefits-Medical)

If a minor is named as beneficiary, insurance proceeds can only be paid to a legally appointed/qualified guardian.

NAME	RELATION	BIRTHDAY	S.S. #	ADDRESS/CITY/STATE/ZIP	%
_____ (Primary)	_____	___/___/___	___-___-___	_____	_____
_____	_____	___/___/___	___-___-___	_____	_____
_____ (Secondary)	_____	___/___/___	___-___-___	_____	_____
_____	_____	___/___/___	___-___-___	_____	_____

I agree to notify the Fund Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that stating false or misleading information or the omission of material information could be grounds for denial of benefits.

_____ _____

MEMBER SIGNATURE **Date**

(OVER)

OTHER INSURANCE INQUIRY

Signature Required Below

Please complete this portion of the form if you, your spouse, or any of your dependents have other insurance coverage, or if there has been any change in other insurance coverage.

General Information:

Name of Other Insured Person: _____

Other Insured Person Date of Birth: _____

Relationship to Member: _____

Information about Other Insurance Plan or Program:

Other Insurance Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Co. Phone #: (_____)_____

Policy/Group Number: _____

Effective date of coverage: _____ Is insurance active? _____

Termination date if applicable: _____

Coverage is: (*circle one*) Single Family

Children are covered until age: _____

Type of coverage: (*circle all that apply*) Medical Dental Vision Prescription

List covered dependents: _____

_____

_____

Member Statement:

The above information is true and accurate to the best of my knowledge and belief. I also am aware of the fact that I must notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage.

Any materials submitted by myself or on behalf of any eligible person that contain a material alteration or forged or false information, including signatures, will be rejected. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers as a result of such material in any matter.

I Have No Other Insurance: _____

Initial Here/Sign Below

_____ _____

Member Signature **Date**