BAC of MICHIGAN
Health and Welfare Fund

P.O. Box 99490 • Troy, MI 48099-9490 • Phone (248) 828-6000 • Fax (248) 828-6001

January 2022

RE: VITAL INFORMATION FORM and IMPORTANT INFO

Dear Participants and Beneficiaries:

You previously received a notice regarding your participation as of January 1, 2022 in the ***BAC of Michigan Health and Welfare Fund*** (BAC of MI Fund).

1. Please find enclosed **VITAL INFORMATION FORM**. We kindly ask you complete the form detailing current dependents, beneficiary and any other coverage you or your family may have available to you. Please return form to the Fund Office in the provided self-addressed return envelope.

2. You should have already received your new ID cards in the mail. Again, please be sure to present and use your new cards that have the BAC of MI Fund's name for any services you receive on and after January 1, 2022.

   Adding the Blue Cross Blue Shield (BCBS) APP to your smart phone is a very helpful tool and may assist with service needs: virtual ID card, Search for Providers and Discount Saving with various companies.

   Please note, if you have not received your new BCBS ID card and need services, your new card info is as follows:

   Enrollee ID # = DWA + old BCBS MI BAC ID #
   New group # = 000071784

   Plans with Rx:
   Rx Bin = 610011
   Rx group = BCBSMAN

3. For Early Retirees, Surviving Spouses of Early Retirees and Permanent & Total Disabled participants, this Plan <u>does not</u> include prescriptions (Rx).

4. For Medicare eligible participants, the Fund Office must know what election you made for your BCBS Medicare Advantage option; either 1, 2, or 3. Please call the Fund Office at (800) 435-4080, if you have not already done so.

5. The BAC of MI Fund <u>*excludes coverage*</u> and will pay <u>*no benefits*</u> for treatment of injuries resulting from an automobile or motor vehicle accident for <u>any non-Medicare participant</u>. You should review your Auto Insurance policies to ensure you have full Personal Injury Protection (PIP) coverage through your Auto Insurance carrier.

6. If you had issues with your medical or prescription coverage after January 1, 2022 where something you thought should be covered was not and you incurred an expense you did not expect to incur, please call the Fund Office at (800) 435-4080 or download the claims reimbursement form from www.bcbsm.com *(note: there are different forms for medical and prescription claims).*

7. The Fund provides Dental benefits (not through Blue Cross Blue Shield).

   Traditional Dental: $400.00 each calendar year OR the Golden Dental Plan.

   Questions regarding Traditional Dental Benefits, please call the Fund Office at (800) 435-4080. Those enrolled in Golden Dental call (800) 451-5918.

   Mail paper claims for Traditional Dental to: BAC of Michigan Health and Welfare Fund P.O. Box 99490, Troy, MI 48099-9490. Send claims electronically: Payer ID: 38238

8. The Fund provides Vision benefits (not through Blue Cross Blue Shield).

   Vision Benefits: Actives once per calendar year and Retirees every two years.
   Exam $50, Single Vision $75, Bi-Focal $100, Tri-Focal $100, Contacts $140 (in lieu of glasses)

   Questions regarding Vision, please call the Fund Office at (800) 435-4080.

   Mail paper claims for Vision to: BAC of Michigan Health and Welfare Fund P.O. Box 99490, Troy, MI 48099-9490. Send claims electronically: Payer ID: 38238

9. If you are an Owner or Non-bargaining unit employee eligible through a participation agreement, new agreements were mailed out and need to be completed & signed or the Trustees may terminate the relationship going forward, which would result in termination of your coverage.

   Please contact the Fund Office if you need a new copy or obtain one through the participant website, www.baclocal2benefits.org

Videos are available at the BAC of MI Fund's website www.baclocal2benefits.org on the Home page Announcement tab discussing the merger and changes for your convenience.

In February and continuing each moth thereafter, you will receive a monthly statement of your eligibility status, covered dependents, work hours, important messages and an option to self-pay, if applicable.

In March, you will receive the new 2022 SPD for the BAC of MI Fund which details the Plan benefits and provisions.

In the meantime, please direct any questions you may have to the Fund Office at (800) 435-4080.

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VITAL INFORMATION FORM

MEMBER INFORMATION **(Please Print) NAME** _____

Social Security Number _____ Telephone Number _____

Date of Birth _____ Sex (circle) Male Female

Marital Status (circle) Single Married Divorced Separated Widowed

Date of Marriage or Divorce _____ Submit copy of Marriage License or Divorce Decree if have not previously done so.

Status (Circle one) Active Retired Disabled COBRA

DEPENDENTS – (Including Spouse)

FULL NAME	RELATIONSHIP	BIRTH DATE	SOCIAL SECURITY #

BENEFICIARY **(Death Benefits)**

FULL NAME	RELATIONSHIP	SEX	DATE OF BIRTH

ADDRESS	CITY	STATE	ZIP

SOCIAL SECURITY NUMBER _____ **(REQUIRED)**

I agree to notify the Fund Office within 90 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**

(BOTH SIDES MUST BE COMPLETED)

OTHER INSURANCE INQUIRY

Please complete and return this 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.

Are you or any of your dependents eligible to enroll in Medicare? YES NO
(Circle one)

If Yes: _____ _____ _____ _____
(Name) Medicare ID Number Effective Date (Part A) (Part B)

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 Company Phone #: (____) _____ **Coverage Type** Single / Family
(Circle one)

Policy: _____ **Group Number** _____

Effective Date: _____ **Termination date if applicable:** _____

Does Coverage Include: Medical YES NO **Dental** YES NO **Vision** YES NO
(Circle answer)

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. I am aware that it is my responsibility to notify the fund of any change or if there is a change in marital status for myself or any of my dependents.

Any materials submitted by myself or on behalf of any eligible person that contains 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.

_____ _____
Member Signature **Date**

_____
PRINT NAME