BAC OF MICHIGAN
Health & Welfare Fund PO Box 99490, Troy, MI 48099-9490
1-800-435-4080

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

Status (Circle one) Active Retired Disabled COBRA

LIST DEPENDENTS * - (Include Spouse & Dependent(s) relationship to our Member)

FULL NAME	RELATIONSHIP	BIRTH DATE	SOC. SECURITY #	HAS OTHER INSURANCE
_____	_____	_____	_____	Yes/No
_____	_____	_____	_____	Yes/No
_____	_____	_____	_____	Yes/No
_____	_____	_____	_____	Yes/No
_____	_____	_____	_____	Yes/No

Please refer to SPD regarding what documents are required for adding dependents

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BENEFICIARY (Death Benefits)

FULL NAME_____RELATIONSHIP_____SEX_____

DATE OF BIRTH_____ SOCIAL SECURITY NUMBER_____**(REQUIRED)**

STREET ADDRESS_____

CITY_____STATE_____ZIP_____

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 PAGES MUST BE COMPLETED)

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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 of Recipient) Medicare ID Number Eff. Dates (Part A) (Part B) (Part D)

Insurance information for Dependent(s) with other Insurance Plans or Programs:

(If more than one, please supply the same information requested below on separate sheet)

Name of Dependent with other Insurance: _____

Date of Birth: _____ Relationship to Our Member_____

Other Insurance Name: _____

Address: _____City: _____ State: _____ Zip Code: _____

Insurance Company Phone #: (_____)_____

Policy: _____ Group Number _____

Effective Date: _____ Termination date if applicable: _____

Coverage Includes: **Medical** YES/NO **Dental** YES/NO **Vision** YES/NO (Circle responses)
Is Coverage Single or Family (Circle one)

If **Family Coverage**, Please list dependents covered under plan:

_____ _____

_____ _____

_____ _____

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 **Print Name** **Date**