CITY OF DETROIT POST-2014 NON-SAFETY EMPLOYEE RETIREE HEALTHCARE TRUST

P.O. BOX 1497
TROY, MICHIGAN 48099-1497
(248) 641-4989

VITAL INFORMATION FORM

Last: _____ First: _____ Middle: _____

Address/City/State/Zip: _____

Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____ Gender : ◯ Male ◯ Female

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed

Date of Marriage/Divorce/Separation: _____

Telephone Number: (_____) _____ Alternate Phone Number: (_____) _____

Email Address: _____

Date of Retirement: _____

DEPENDENTS: - Include Spouse (***Marriage/Birth Certificates are required to add any dependents to the plan)***

FULL NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER

Is your spouse a General City of Detroit Retiree? ◯ Yes ◯ No _____
Spouse Retirement Date

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**

Return form to BeneSys, Inc. via email (enrollmentdocs@benesys.com), fax (248) 430-8222, or mail.