MICHIGAN GLASS and GLAZING INDUSTRY
FRINGE BENEFIT FUNDS

P.O. Box 966
Troy, MI 48099-0966
Telephone: (248) 641-4957

VITAL INFORMATION ENROLLMENT FORM

EMPLOYEE'S FULL NAME: _____ S.S.#: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP _____ DATE OF BIRTH _____ SEX: _____Male _____Female

CURRENT LOCAL UNION AFFILIATION: _____

EMPLOYMENT CLASSIFICATION: _____

DEPENDENTS - (Including Spouse)

(**ATTACH LEGAL DOCUMENTATION** that applies: birth certificate/s, marriage certificate, adoption papers, guardianship papers, divorce papers and proof of support.)

FULL NAME	RELATIONSHIP	BIRTH DATE	SOCIAL SECURITY NUMBER

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.

DATE: _____ MEMBER'S SIGNATURE: _____

BENEFICIARY DESIGNATION

I hereby revoke any other beneficiary designation I have declared and designate each person named below as a beneficiary under any group life insurance policy which may cover me under eligibility rules and other terms and conditions of the Michigan Glass and Glazing Fringe Benefit Funds. Each person named below shall receive an equal share of any distribution, unless I otherwise specify, in percentage(s) which add up to 100%.

FULL NAME	RELATIONSHIP	BIRTH DATE	PERCENTAGE

DATE: _____ MEMBER'S SIGNATURE: _____

Please note that if a minor is named as beneficiary, insurance proceeds can only be paid to a legally appointed and qualified guardian.

YOU MUST COMPLETE AND SIGN THE REVERSE SIDE OF THIS FORM.

COORDINATION OF BENEFITS INQUIRY

THE FOLLOWING PERTAINS TO ANY OTHER HEALTH INSURANCE WHICH ANY FAMILY MEMBER MAY HAVE OR HAVE BEEN OFFERED THROUGH EMPLOYMENT, EXCEPT COVERAGE WHICH IS PROVIDED BY THIS PLAN OR ON MEDICARE.

A. General Information

Member's Name: _____ Member's SS#: _____
Spouse's Name: _____
Other Parent's Name and birth date: _____
Is Spouse or Other Parent employed? YES _____ (If yes, section B must be completed)
NO _____ (If no, please skip to section C)

B. Employment Statement (Spouse or other parent must answer the following.)

Was Health coverage offered to you?
YES NO (circle one) Coverage Effective Date: _____ Group#_____
Name of Insurance Carrier: _____
If NO, state reason_____
Was Dental coverage offered to you?
YES NO (circle one) Coverage Effective Date: _____ Group#_____
Name of Insurance Carrier: _____
If NO, state reason_____
Was Vision coverage offered to you?
YES NO (circle one) Coverage Effective Date: _____ Group#_____
Name of Insurance Carrier: _____
If NO, state reason_____
Was Prescription Drug coverage offered to you?
YES NO (circle one) Coverage Effective Date: _____ Group#_____
Name of Insurance Carrier: _____
If NO, state reason_____

Did you decline to enroll for any of the above coverage? If so, why? _____
Are you required to make a contribution to maintain any of the above named coverage? YES NO (circle one)
Dependent coverage included? YES NO (circle one)

ADDITIONAL COMMENTS (please list Group number and Policy number if enrolled in other coverage)
_____
_____
_____

Completed By: _____ Relationship to Member: _____
Name and Address: _____
_____
Date: _____ Telephone No: _____

Thank you for your cooperation.

C. 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 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 manner.

MEMBER'S SIGNATURE: _____
MEMBER'S TELEPHONE NUMBER:_____
DATE:_____

PLEASE RETURN THIS FORM TO THE ABOVE ADDRESS. THANK YOU.