SHEET METAL WORKERS' LOCAL UNION NO. 80
FRINGE BENEFIT FUNDS

P.O. Box 1408 / Troy, MI. 48099-1408 / (248) 641-4980 (800) 400-7710

VITAL INFORMATION FORM

PARTICIPANT Information: *(Please Print)*

Last name: _____ First name: _____ MI: _____

Address/City/State/Zip:_____

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

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

Current Marital Status: (*circle one*) Single Married Divorced Separated Widowed

You must provide the Fund with a copy of any divorce or separation judgment within 60 days of its entry with the Court. Failure to do so will result in your liability for any claims filed after its entry.

Medicare Claim Number: (including the letter(s) that follows the number)
(Complete if participant, spouse, or a covered dependent is covered by Medicare)

Participant # _____ **Spouse #** _____ **Dependent # and Name**_____

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

FULL NAME	RELATION	BIRTH DATE	SOCIAL SECURITY NUMBER

Attach documents showing proof of dependent status for each dependent listed above, example marriage & birth certificates, step children are not atomically covered, please contact Fund Office for required documents.

BENEFICIARY(ies): (For purposes of any benefit which may be payable upon your death)

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)	_____	___/___/___	___-___-___	_____	_____

Designation of a spouse as beneficiary terminates immediately upon entry of a judgment of divorce

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.

_____ _____

Participant's Signature **Date**

(over)

OTHER INSURANCE INQUIRY

Without completion and signing of this form, your spouse will not be added as a dependent.

1. SPOUSE'S EMPLOYMENT DATA

My spouse is (check one): _____ Employed Full Time

_____ Employed Part Time (if part time, please list hours worked per week _____)

_____ Not employed

If your spouse is not employed, STOP HERE and sign at the bottom.

If your spouse is employe d, please continue:

Spouse's Employer: _____

Address/City/State/Zip:_____

Is health care coverage offered or available to your spouse through your spouse's employer?

_____ Yes.

_____ No. If no, please indicate why:

_____ My spouse works part-time and coverage is not available

_____ Coverage is not available for any employees

_____ Coverage is available, but was declined because_____

_____ Other: (Please explain) _____

If health care coverage is offered or available to your spouse, your spouse's employer must complete the following Section.

2. INFORMATION ABOUT OTHER INSURANCE PLAN OR PROGRAM/EMPLOYER STATEMENT.

Employer Name: _____

Name of Insurance Carrier: _____ Policy/Group number:_____

Is Your Employee Covered? YES NO Effective Date of Coverage: _____

Termination Date If Applicable: _____

Did your employee decline to enroll for any coverage(s)? YES NO, If yes when and why?_____

_____

Employee's Coverage is: (*circle one*) Single Two-person Family

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

List covered dependents: _____

Completed By:_____ Title:_____

Company Name and Address: _____

Date:_____ Telephone No: _____

Thank you for your cooperation.

Participant Statement:

*The above information is true and accurate to the best of my knowledge and belief. I acknowledge that I **must** notify the Fund Office immediately should any of the foregoing information change or should any of my dependents become eligible for other coverage*

_____ _____

Participant Signature **Date**