



**PLUMBERS LOCAL 98  
FRINGE BENEFIT FUNDS**

P.O. BOX 159  
TROY, MICHIGAN 48099-0159  
(248) 641-4988 (866) 646-8919

**VITAL INFORMATION FORM**

**MEMBER Information:** *(Please Print)*

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Address/City/State/Zip: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Telephone Number: (\_\_\_\_) \_\_\_\_\_

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

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

Date of Marriage/Divorce/Separation: \_\_\_\_\_

Current Status: *(circle one)* Active Retired Disabled COBRA

**Medicare Claim Number: (including the letter(s) that follows the number)**  
*(This only applies when a member, a spouse, or a covered dependent is age 65 or older or on Medicare disability)*

Member # \_\_\_\_\_ Spouse # \_\_\_\_\_ **Dependent # and Name** \_\_\_\_\_

**DEPENDENTS: - Include Spouse** (If additional space is needed, please use 2<sup>nd</sup> sheet)

FULL NAME	RELATION	BIRTH DATE	SOCIAL SECURITY NUMBER
_____	_____	____/____/____	____-____-____
_____	_____	____/____/____	____-____-____
_____	_____	____/____/____	____-____-____

*\*\*Verification of dependent status is required for each child age 19-25.*

**BENEFICIARY(ies): (Death Benefits-Medical)**

**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)					
_____	_____	____/____/____	____-____-____	_____	_____

*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

**(OVER)**

## OTHER INSURANCE INQUIRY

*You must complete this portion of the 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.*

### **General Information:**

Name of Other Insured Person: \_\_\_\_\_

Other Insured Person Date of Birth: \_\_\_\_\_

Relationship to Member: \_\_\_\_\_

### **Information about Other Insurance Plan or Program:**

*\*Note: If dependent(s) has/have more than one insurance, please use additional sheet.*

Other Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Insurance Co. Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Policy/Group Number: \_\_\_\_\_

Effective date of coverage: \_\_\_\_\_ Is insurance active? \_\_\_\_\_

Termination date if applicable: \_\_\_\_\_

Coverage is: (*circle one*)      Single      Family

Children are covered until age: \_\_\_\_\_

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

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.*

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

**If you do not have other insurance please initial here:** \_\_\_\_\_

\_\_\_\_\_  
**Member Signature**

\_\_\_\_\_  
**Date**