MICHIGAN STATE PAINTERS INSURANCE FUND

Managed for the Trustees by: TIC INTERNATIONAL CORPORATION

ANNUAL COORDINATION OF BENEFITS AND DEPENDENT STATUS STATEMENT

(Please Type or Print Clearly)

Participant's Name | Birth Date | Member ID or SS# | Telephone Number

Address:

MARITAL STATUS (Check One): **Married** **Single** **Divorced** **Widow** **Separated**

Spouse's Name | Birth Date | Social Security No.

Names of Children Under Age 19	Relationship	Birth Date	Social Security No.

FAMILY CONTINUATION COVERAGE

NOTE: PLEASE LIST ALL CHILDREN BETWEEN AGE 19 AND 26 ON THE REVERSE SIDE OF THIS FORM

Are you or your dependents covered by any other medical insurance? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.
Check One: **Yes** **No** If Yes, please complete the section below:

Effective date of other medical insurance:______________________________________Is this policy (Check One) Group Individual

Name of Other Insurance | Telephone number

Address of Other Insurance

Policy Number | Group Number | Policyholder's Name

Family Members Covered under the Policy

Are you or your dependents covered by any other dental insurance? Check One: **Yes** **No** If Yes, please complete the section below:

Effective date of other dental insurance:______________________________Is this policy (Check One) Group Individual

Name of Other Insurance | Telephone number

Address of Other Insurance

Policy Number | Group Number | Policyholder's Name

Family Members Covered under the Policy

Are you or your dependents covered by any other vision insurance? Check One: **Yes** **No** If Yes, please complete the section below:

Effective date of other vision insurance:______________________________Is this policy (Check One) Group Individual

Name of Other Insurance | Telephone number

Address of Other Insurance

Policy Number | Group Number | Policyholder's Name

Family Members Covered under the Policy

Return this form to: MICHIGAN STATE PAINTERS INSURANCE FUND, 6525 Centurion Drive, Lansing MI 48917

PLEASE READ CAREFULLY AND SIGN BELOW

I have read the information describing the special enrollment opportunity for adult children and understand the participation conditions and requirements. By signing below, I certify that: 1) the information provided above is correct; 2) All adult child coverage is contingent upon me maintaining my eligibility under the Plan; 3) I will be financially responsible for any claims paid for ineligible adult children if the claims were paid based upon inaccurate or misleading information I provide. I understand that if I intentionally falsify any of the above information, Medical claims may be denied and I may be subject to litigation by the Fund. I also understand that I must notify the Fund of any changes in the above information within 30 days of any change.

Member's Signature: **Date:**

Spouse's Signature: **Date:**

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ADULT CHILD UNDER AGE 26

PLEASE LIST BELOW

(If you have more than two adult children under age 26, please use a separate sheet of paper)

NAME OF ADULT CHILD **SOCIAL SECURITY NO.**

COMPLETE ADDRESS OF ADULT CHILD **BIRTH DATE**

FAMILY CONTINUATION COVERAGE

Does your adult child's employer or spouse provide the opportunity for coverage in a health care plan? Check One **Yes** **No**

Are you, your dependents or adult child(ren) under age 26 covered by any other medical insurance? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.

Check One **Yes** **No** If Yes, please complete the section below:

Effective date of other medical insurance:____________________________________Is this policy (check one) Group Individual?

Name of Other Insurance Telephone number

Address of Other Insurance

Policy Number Group Number Policyholder's Name

Family Members Covered under the Policy

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FAMILY CONTINUATION COVERAGE

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Are you, your dependents or adult child(ren) under age 26 covered by any other medical insurance? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.

Check One **Yes** **No** If Yes, please complete the section below:

Effective date of other medical insurance:____________________________________Is this policy (check one) Group Individual?

Name of Other Insurance Telephone number

Address of Other Insurance

Policy Number Group Number Policyholder's Name

Family Members Covered under the Policy