MICHIGAN CARPENTERS' HEALTH CARE FUND

(Managed for the Trustees by: TIC INTERNATIONAL CORPORATION)

REQUEST FOR EXTENSION OF COVERAGE FOR AN ADULT CHILD UNDER AGE 26

(Please Type or Print Clearly)

Participant's Name | Birth Date | Member ID (MID) OR SS# | Telephone Number

Participant's Address: _____
Street | City | State | Zip

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

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

Dependents' Names (List All) | Relationship | Birth date | Social Security No.

ADULT CHILD UNDER AGE 26 FOR WHICH THE EXTENSION OF COVERAGE IS REQUESTED

(If more than one such adult child, please use the reverse side of this form.)

EFFECTIVE DATE FOR THE COVERAGE OF THE ADULT CHILD UNDER AGE 26 WILL BE THE MONTH FOLLOWING RECEIPT OF THIS FORM

NAME OF ADULT CHILD | **SOCIAL SECURITY NUMBER**

ADDRESS OF ADULT CHILD | **BIRTH DATE**

FAMILY CONTINUATION COVERAGE

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 (circle one) Group or Individual?

Name of Other Insurance | Telephone number

Address of Other Insurance

Policy Number | Group Number | Policyholder's Name

Family Members Covered under the Policy

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:**

THIS FORM MUST BE RETURNED TO THE FUND WITHIN 30 DAYS.

Return this form to: MICHIGAN CARPENTERS' HEALTH CARE FUND
6525 Centurion Drive, Lansing MI 48917

MICHIGAN CARPENTERS' HEALTH CARE FUND

ADULT CHILD UNDER AGE 26 FOR WHICH THE EXTENSION OF COVERAGE IS REQUESTED

(If more than one such adult child, please use this side of this form.)

PARTICPANT'S NAME | **MEMBER ID (MID) OR SS NUMBER**

EFFECTIVE DATE FOR THE ADULT CHILD'S COVERAGE WILL BE THE MONTH FOLLOWING RECEIPT OF THIS FORM

NAME OF ADULT CHILD | **SOCIAL SECURITY NUMBER**

COMPLETE ADDRESS OF ADULT CHILD | **BIRTH DATE**

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 (circle one) Group or Individual?

Name of Other Insurance | Telephone number

Address of Other Insurance

Policy Number | Group Number | Policyholder's Name

Family Members Covered under the Policy

NAME OF ADULT CHILD | **SOCIAL SECURITY NUMBER**

ADDRESS OF ADULT CHILD | **BIRTH DATE**

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 (circle one) Group or Individual?

Name of Other Insurance | Telephone number

Address of Other Insurance

Policy Number | Group Number | Policyholder's Name

Family Members Covered under the Policy