If you, your spouse, or any eligible dependent children have Medicare or a Social Security Disability Award please forward a copy to the Fund office.

MICHIGAN CARPENTERS' HEALTH CARE FUND
MEDICARE INFORMATION FORM

PLEASE COMPLETE THIS FORM IF YOU, YOUR SPOUSE AND/OR DEPENDENT(S) HAVE **NOT** REPORTED YOUR MEDICARE ELIGIBILITY OR MEDICARE ENROLLMENT TO THE FUND

PARTICIPANT

Name_____

SS#_____ Date of Birth_____

Marital Status ☐SINGLE ☐MARRIED ☐WIDOWED ☐DIVORCED ☐SEPARATED

Do you have a **SOCIAL SECURITY DISABILITY AWARD**? ☐NO ☐YES
If yes – submit a copy of your Social Security Disability Award along with this form

Are you enrolled in Medicare D? ☐NO ☐YES

Are you enrolled in a Medicare Advantage Program? ☐NO ☐YES

Are you eligible for but not enrolled in Medicare? ☐NO ☐YES

If you are enrolled in Medicare, please provide the following information:

Please provide your Medicare insurance information

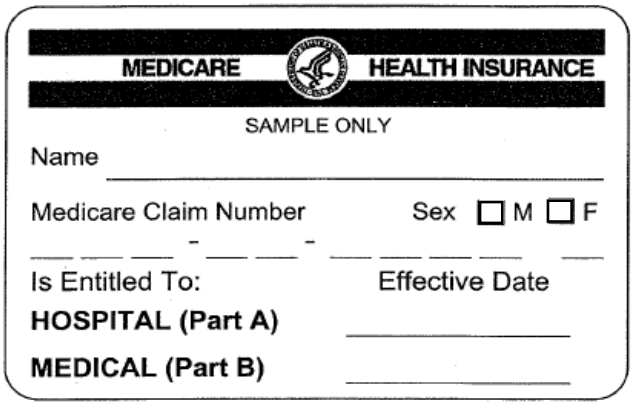
Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card

- OR -

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A and Part B



▲This is for YOUR Medicare Information▲

SPOUSE

Spouse's Name_____

Spouse's SS#_____ Spouse's Date of Birth_____

Does your **Spouse** have a **SOCIAL SECURITY DISABILITY AWARD**? ☐NO ☐YES
If yes – submit a copy of the Social Security Disability Award along with this form
Is your spouse enrolled in Medicare D? ☐NO ☐YES

Is your spouse enrolled in any Medicare Advantage Program? ☐NO ☐YES

Is your spouse eligible for, but not enrolled in Medicare? ☐ NO ☐ YES
If your spouse is enrolled in Medicare, please provide your spouse's information:

Please provide your Medicare insurance information

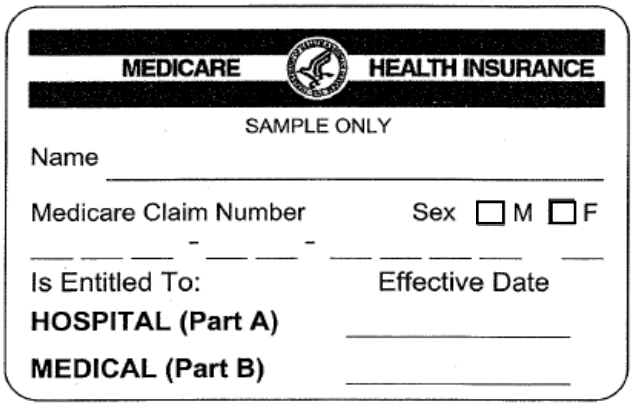
Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card

- OR -

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A and Part B



▲This is for your SPOUSE'S Medicare Information▲

DEPENDENT

Dependent's Name_____

Dependent's SS#_____ Dependent's Date of Birth_____

Medicare Effective Date _____

IF APPLICABLE, PLEASE SEND A COPY OF YOUR DEPENDENT'S MEDICARE CARD WITH THIS COMPLETED FORM.

IF ANY OF THE ABOVE INFORMATION CHANGES, IT IS YOUR RESPONSIBILITY TO CONTACT THE FUND OFFICE, IMMEDIATELY.

I/WE CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE.

_____ _____

Date Signature of Participant

_____ _____

Date Signature of Spouse

Daytime telephone number: _____

(PLEASE INCLUDE AREA CODE)

Please mail your completed form to:

Michigan Carpenters' Health Care Fund
6525 Centurion Drive
Lansing, MI 48917