Roofers Union Local No. 70
Fringe Benefits Office

PO Box 766, Howell, MI 48844-0766
Phone: (517) 548-7941 ~ Fax: (517) 548-5936 ~ office@roofers70benefits.com

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 2nd sheet)

FULL NAME	RELATIONSHIP	BIRTHDATE	SOC SEC NO
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Children are eligible for coverage until attaining 26 years of age*

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	%
_____	_____	__/__/___	___-___-____	_____	____
_____	_____	__/__/___	___-___-____	_____	____
_____	_____	__/__/___	___-___-____	_____	____
_____	_____	__/__/___	___-___-____	_____	____

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

Please provide the following information if you, your spouse, or any of your dependents have other insurance coverage, or please complete the certification of no other insurance coverage at the end of this form.

General Information:

Name of Other Insured Person: _____

Other Insured Person Date of Birth: _____

Relationship to Member: _____

Information about Other Insurance Plan or Program:

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.

I Have No Other Insurance: _____
Initial Here/Sign Below

_____ _____

Member Signature **Date**