Duluth Building Trades Health Fund

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FAMILY UPDATE FORM

Directions: Complete this Family Update Form and return it to the Fund Office. **You must submit the following items to the Fund Office with this Family Update Form, if you have not previously provided them to the Fund Office (as applicable):**

- If you or your Dependent(s) have other group medical coverage, you must include a photocopy of the front and back of the I.D. card for the other coverage.
- If you are married, you must include a copy of your Marriage Certificate
- If you are enrolling a Dependent child(s), you must include a copy of the child's birth certificate, adoption papers, or court order for custody and support or maintenance (as applicable). If there is a divorce decree that addresses medical coverage for any Dependent Child, please supply a copy of the decree.

Insured's Data

Name:	Social Security Number:
Date of Birth:	Phone Number:
Address:	Marital Status: ❑ Single ❑ Married ❑ Divorced Date of Marriage or Divorce: _____
Local:	Do you have other insurance? Yes ☐ No ☐ (If yes, please attach copy of other insurance card)

Spouse's Data

Name:	Social Security Number:
Date of Birth:	Phone Number:
Spouse's Employer Name:	Employer's Address:
Employer's Phone Number:	

Spouse's Insurance Data

Does your spouse have other Group Medical Coverage? ❑ Yes ❑ No	If yes, is the coverage type: ❑ Single or ❑ Family
Medical Insurance Carrier Name:	Insurance Carrier Phone Number:
Insurance Carrier Address:	Group Contract Number: Effective Date:_____ Term Date: _____
Does coverage include Dental? ❑ Yes ❑ No	Does coverage include Vision? ❑ Yes ❑ No

Dependent Child Information:

Make sure you fill out ALL the below information for each Dependent that is eligible for coverage from the Plan. **It is extremely important that you list each of your Dependent children that is under the age of 26.** If you have more than six eligible Dependents, please attach a separate sheet of paper with information regarding those additional Dependents and list your name at the top of that sheet of paper.

Dependent's Name	Relationship	DOB	Soc. Sec. No.	Sex	Other Insurance/Employer	
					❑ Yes ❑ No	
					❑ Yes ❑ No	
					❑ Yes ❑ No	
					❑ Yes ❑ No	
					❑ Yes ❑ No	
					❑ Yes ❑ No	

If any of the information changes during the calendar year, you must advise us immediately

OVER

Medicare Information including Medicare Part D - Prescription Drug Program

Your Name:_____ Date of Birth _____ /_____ /_____ Medicare HIC #: _____

Effective Date: Part A: _____ /_____ /_____ Part B: _____ /_____ /_____ Part D: _____ /_____ /_____

Spouse's Name:_____ Date of Birth _____ /_____ /_____ Medicare HIC #: _____

Effective Date: Part A: _____ /_____ /_____ Part B: _____ /_____ /_____ Part D: _____ /_____ /_____

If you are retired, please indicate retirement date: You: _____ /_____ /_____

Do you have Medicare due to:
❑ End-stage renal disease and/or ❑ disability ? Effective Date: _____ /_____ /_____

Does your spouse have Medicare due to
❑ End-stage renal disease and/or ❑ disability ? Effective Date: _____ /_____ /_____

Life-Changing Events

If you get married, provide the Fund Office with:
• A copy of your marriage certificate
• Your spouse's date of birth
• A copy of your spouse's medical insurance information, if he or she is covered under another plan

If you add a child, provide the Fund Office with:
• The birth certificate, effective date of adoption papers, court order, or marriage certification (for stepchildren)
• A copy of your child's other medical insurance information, if he or she is covered under another plan

If you get legally separated or divorced, provide the Fund Office with:
• A copy of your separation or divorce decree
• A copy of any QDRO
• If you have children for whom you do not have custody, a copy of any QMCSO

If your spouse wants to continue coverage, he or she must:
• Contact the Fund Office; and
• Enroll for COBRA Continuation Coverage

Beneficiary(ies)

Name	Relationship	Date of Birth	SSN	Address	Phone Number

We are pleased to be of service to you. Please contact this office if you have any questions. **The following is extremely important information. Please read this language carefully and then sign and date this Family Update Form and return it to the Fund Office.**

I hereby certify that all information provided on this Family Update Form is correct to the best of my knowledge. I understand that if this information changes, it is my responsibility to notify the Fund Office immediately. I also understand that I will be required to reimburse the Plan for any payments made as a result of my failure to notify the Fund Office of a change in the information provided on this Family Update Form. My signature will also authorize an institution or physician to release information concerning my enrollment, related records and medical records to the Fund Office, if needed. This Form supersedes any previously completed Family Update Form or Beneficiary Designation Form.

_____ _____

Participant's Signature *Date of Signature*