ENROLLMENT CARD

MICHIGAN CONFERENCE OF TEAMSTERS WELFARE FUND (MCTWF)

2700 Trumbull Avenue, Detroit, Michigan 48216

Phone: (313) 964-2400 or (800) 572-7687 Fax: (313) 748-4330 www.mctwf.org

OFFICE USE ONLY

PLEASE PRINT (All sections must be completed in their entirety, otherwise the card will be returned. If any portion of a section is not applicable to you, indicate "N/A")

PLEASE NOTE: Regardless of any other health coverage that you and your family may have and regardless of whether or not you wish to participate in MCTWF, you must complete and submit this card to MCTWF. Your failure to do so will result in your employer being billed for contributions on your behalf at the full family rate until MCTWF receives this completed card.

PARTICIPANT SECTION

RETURN THIS CARD TO MCTWF AT THE ABOVE ADDRESS

NAME (Last— First—Middle) ☐ MR. ☐ MS. | BIRTH NAME, if different (Last— First—Middle) | SOCIAL SECURITY NO. | DATE OF BIRTH (mm/dd/yyyy)

RESIDENTIAL ADDRESS # and STREET NAME APT.# /LOT# / BLDG.# etc. | **MAILING ADDRESS** (if different than residential address) # and STREET NAME PO BOX /APT.# /LOT# /BLDG.#/etc.

CITY STATE ZIP | CITY STATE ZIP

SEX ☐ MALE ☐ FEMALE | MARITAL STATUS ☐ SINGLE ☐ MARRIED | PHONE NUMBER | EMAIL ADDRESS | DATE OF HIRE (mm/dd/yyyy) | LOCAL UNION NO.

EMPLOYER/COMPANY NAME AND LOCATION | If participant has other group health plan coverage, provide the name of the Plan or Insurance Carrier:

SPOUSE SECTION

If you are married, you are required to fill out this section (Marriage Certificate required). If spouse has medical coverage other than through the participant's plan, please state the name of the plan or the insurance carrier.

NAME (Last— First—Middle) ☐ MR. ☐ MS. | BIRTH NAME, if different (Last— First—Middle) | SOCIAL SECURITY NO. | DATE OF BIRTH (mm/dd/yyyy)

RESIDENTIAL ADDRESS # and STREET NAME APT.# /LOT# / BLDG.# etc. | **MAILING ADDRESS** (if different than residential address) # and STREET NAME PO BOX /APT.# /LOT# /BLDG.#/etc.

CITY STATE ZIP | CITY STATE ZIP

EMPLOYER/COMPANY NAME AND LOCATION | DATE OF HIRE (mm/dd/yyyy) | SEX ☐ MALE ☐ FEMALE

IF SPOUSE HAS MEDICAL COVERAGE OTHER THAN THROUGH THE PARTICIPANT, PLEASE STATE THE NAME OF THE PLAN OR THE INSURANCE CARRIER:

CHILDREN SECTION

All dependent children under age 26 are required to be listed. The "RELATIONSHIP" section refers to the child's relationship to the participant. Use a second enrollment card if space provided is not sufficient (Birth Certificate required for each child). Also required are any applicable Qualified Medical Child Support Orders.

CHILD'S NAME (Last— First—Middle) | BIRTH NAME, if different (Last— First—Middle) | ADDRESS (if different from participant) | RELATIONSHIP ☐ CHILD ☐ WARD ☐ STEPCHILD | GENDER ☐ MALE ☐ FEMALE | SOCIAL SECURITY NO | DATE OF BIRTH (mm/dd/yyyy)

CHILD IS COVERED UNDER OTHER GROUP HEALTH PLAN COVERAGE: ☐ YES ☐ NO IF YES, NAME OF CARDHOLDER: DATE OF BIRTH (mm/dd/yyyy):

IF THE CHILD HAS MEDICAL COVERAGE OTHER THAN THROUGH THE PARTICIPANT'S PLAN, PLEASE STATE THE NAME OF THE PLAN OR INSURANCE CARRIER:

CHILD'S NAME (Last— First—Middle) | BIRTH NAME, if different (Last— First—Middle) | ADDRESS (if different from participant) | RELATIONSHIP ☐ CHILD ☐ WARD ☐ STEPCHILD | GENDER ☐ MALE ☐ FEMALE | SOCIAL SECURITY NO | DATE OF BIRTH (mm/dd/yyyy)

CHILD IS COVERED UNDER OTHER GROUP HEALTH PLAN COVERAGE: ☐ YES ☐ NO IF YES, NAME OF CARDHOLDER: DATE OF BIRTH (mm/dd/yyyy):

IF THE CHILD HAS MEDICAL COVERAGE OTHER THAN THROUGH THE PARTICIPANT'S PLAN, PLEASE STATE THE NAME OF THE PLAN OR INSURANCE CARRIER:

CHILD'S NAME (Last— First—Middle) | BIRTH NAME, if different (Last— First—Middle) | ADDRESS (if different from participant) | RELATIONSHIP ☐ CHILD ☐ WARD ☐ STEPCHILD | GENDER ☐ MALE ☐ FEMALE | SOCIAL SECURITY NO | DATE OF BIRTH (mm/dd/yyyy)

CHILD IS COVERED UNDER OTHER GROUP HEALTH PLAN COVERAGE: ☐ YES ☐ NO IF YES, NAME OF CARDHOLDER: DATE OF BIRTH (mm/dd/yyyy):

IF THE CHILD HAS MEDICAL COVERAGE OTHER THAN THROUGH THE PARTICIPANT'S PLAN, PLEASE STATE THE NAME OF THE PLAN OR INSURANCE CARRIER:

(Over)

CHILDREN SECTION *(continued)*						
CHILD'S NAME (Last— First—Middle)	BIRTH NAME, if different (Last— First—Middle)	ADDRESS (if different from participant)	RELATIONSHIP ☐ CHILD ☐ WARD ☐ STEPCHILD	GENDER ☐ MALE ☐ FEMALE	SOCIAL SECURITY NO	DATE OF BIRTH (mm/dd/yyyy)
CHILD IS COVERED UNDER OTHER GROUP HEALTH PLAN COVERAGE: ☐ YES ☐ NO		IF YES, NAME OF CARDHOLDER:		DATE OF BIRTH (mm/dd/yyyy):		
IF THE CHILD HAS MEDICAL COVERAGE OTHER THAN THROUGH THE PARTICIPANT'S PLAN, PLEASE STATE THE NAME OF THE PLAN OR INSURANCE CARRIER:						
CHILD'S NAME (Last— First—Middle)	BIRTH NAME, if different (Last— First—Middle)	ADDRESS (if different from participant)	RELATIONSHIP ☐ CHILD ☐ WARD ☐ STEPCHILD	GENDER ☐ MALE ☐ FEMALE	SOCIAL SECURITY NO	DATE OF BIRTH (mm/dd/yyyy)
CHILD IS COVERED UNDER OTHER GROUP HEALTH PLAN COVERAGE: ☐ YES ☐ NO		IF YES, NAME OF CARDHOLDER:		DATE OF BIRTH (mm/dd/yyyy):		
IF THE CHILD HAS MEDICAL COVERAGE OTHER THAN THROUGH THE PARTICIPANT'S PLAN, PLEASE STATE THE NAME OF THE PLAN OR INSURANCE CARRIER:						

DEATH BENEFIT BENEFICIARY SECTION – ONLY FOR PARTICIPANTS WITH DEATH BENEFIT COVERAGE OR UNPAID TOTAL AND PERMANENT DISABILITY BENEFITS AT THE TIME OF DEATH. ***IF YOU DO NOT INDICATE OTHERWISE, THE BENEFICIARIES WILL RECEIVE EQUAL SHARES OF YOUR BENEFIT.***

NAME OF BENEFICIARY (LAST— FIRST—MIDDLE)	FULL ADDRESS OF BENEFICIARY (City, State, Zip Code)	DATE OF BIRTH	% OF BENEFIT	RELATIONSHIP TO PARTICIPANT	SOCIAL SECURITY NO
NAME OF BENEFICIARY (LAST— FIRST—MIDDLE)	FULL ADDRESS OF BENEFICIARY (City, State, Zip Code)	DATE OF BIRTH	% OF BENEFIT	RELATIONSHIP TO PARTICIPANT	SOCIAL SECURITY NO
NAME OF BENEFICIARY (LAST— FIRST—MIDDLE)	FULL ADDRESS OF BENEFICIARY (City, State, Zip Code)	DATE OF BIRTH	% OF BENEFIT	RELATIONSHIP TO PARTICIPANT	SOCIAL SECURITY NO

THE PERCENT OF BENEFITS MUST TOTAL 100%. IF THEY DO NOT OR NO PERCENTAGE OF DESIGNATION IS MADE, THE LIVING BENEFICIARIES WILL RECEIVE EQUAL SHARES OF YOUR BENEFIT. BEFORE PAYMENT OF A DEATH BENEFIT CAN BE MADE TO A DESIGNATED BENEFICIARY WHO IS A MINOR, AN ORDER ISSUED BY THE PROBATE COURT APPOINTING A GUARDIAN OR CONSERVATOR WITH FULL AUTHORITY TO ACCESS, RECEIVE, AND DISPOSE OF THE NAMED MINOR'S ASSETS, MUST BE PROVIDED TO MCTWF.

By signing this card, I certify that the information provided is complete and accurate as of the date of my signature.

I agree to promptly notify MCTWF of any changes in or additions to the information stated in this card.

I understand that if I do not provide complete and accurate information or do not promptly notify MCTWF of changes in information, my benefits may be suspended until I have provided complete and accurate information to MCTWF.

I also understand that the submission of this enrollment card does not guarantee coverage.

I further understand that MCTWF has the right to recover from me any payments caused by, but not limited to, my failure to provide complete, accurate and timely information to MCTWF.

_____ _____

PARTICIPANT SIGNATURE **DATE**

If you do not speak English and you have required assistance in reading this form, please state your primary language: _____

_____

Rev 12/23