OUTSTATE MICHIGAN TROWEL TRADES
HEALTH & WELFARE FUND

RETIREE INFORMATION FORM

(TO BE COMPLETED BY DISABLED AND RETIRED PARTICIPANTS)

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.

Name_____

Member ID or SS #_____ Date of Birth _____ Local _____

Do you have a **SOCIAL SECURITY DISABILITY AWARD**? ☐ NO ☐ YES

Do you have part **A** and **B** of **MEDICARE**? ☐ NO ☐ YES

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

Spouse's Name_____

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

Does your **Spouse** have a SOCIAL SECURITY DISABILITY AWARD? ☐ NO ☐ YES

Does your **Spouse** have part **A** and **B** of MEDICARE? ☐ NO ☐ YES

Do you have any eligible dependent children that should be covered under the Outstate Michigan Trowel Trades Health & Welfare Fund? ☐ NO ☐ YES

IF "YES", STATE FULL NAME OF DEPENDENT AND DATE OF BIRTH

Name _____ Date of Birth _____

Name _____ Date of Birth _____

If any of the children listed above have MEDICARE, please indicate which child and their MEDICARE EFFECTIVE DATE. **PLEASE SEND A COPY OF THEIR 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 AND BELIEF.

_____ _____

Date Signature of Participant

_____ _____

Date Signature of Spouse