MICHIGAN ELECTRICAL EMPLOYEES' HEALTH PLAN

Managed for the Trustees by: Wilson-McShane Corporation

Participant Data Form

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 Participant Data Form and return it to the Fund Office.** Forms along with photos of the required documents can be emailed to **enrollment@wilson-mcshane.com.**

I hereby certify that all information provided on this Participant Data 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 Participant Data Form. Your Signature will also authorize an institution or physician to release information concerning your enrollment, related records and medical records to the fund office, if needed.

_____ _____

Participant's Signature Date of Signature

Insured's Data

Name:	Do you have other insurance? Yes ◯ No ◯ (If yes, attach a copy of other insurance ID card)
Social Security Number:	Phone Number:
Date of Birth:	Email Address:
Street Address: City/State/Zip :	Home Local #: ◯ Bargaining Employee ◯ Non-Bargaining Employee

Spouse's Data **(Copy of Marriage Certificate* Required)**

Name:	Marital Status: ◯ Single ◯ Married ◯ Divorced Date of Marriage or Divorce:
Social Security Number:	Phone Number:
Date of Birth:	Email Address:

Spouse's Insurance Data

Does your spouse have other insurance? ◯ Yes ◯ No (If yes include a copy of the other insurance ID cards)	If yes, is the coverage type: ◯ Single or ◯ Family	Policy Coverages: ☐ Medical ☐ Pharmacy ☐ Dental ☐ Vision
Medical Insurance Carrier Name: Insurance Carrier Phone Number:	ID #:	Group #:
Policy Effective Date:	Policy Term Date (If applicable):	
Policyholder's Relationship To Dependent:	Policyholder's Employer: (if applicable)	

Dependent Child Information **(COPY OF BIRTH CERTIFICATE*, ADOPTION PAPERS OR COURT ORDERS REQUIRED)**

- **Complete a COB Form for each child under the age of 18 when both biological parents are not covered by the plan.**
- **Complete a COB Form for each child over the age of 18**

Dependent's Name	**Relationship**	**DOB**	**Soc. Sec.No.**	**Sex**	**Do they have other Insurance**	**Employer/Other Insurance** (If yes include a copy of the other insurance ID cards)
					Yes ◯ No ◯	
					Yes ◯ No ◯	
					Yes ◯ No ◯	
					Yes ◯ No ◯	
					Yes ◯ No ◯	
					Yes ◯ No ◯	
					Yes ◯ No ◯	

If you have more than seven eligible Dependents, please attach a separate sheet of paper with information regarding those additional Dependents and

*Certificates must be copies of an official state or county issued document.

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COORDINATION OF BENEFITS (COB) FORM

Insured's Data:

Name:	
Social Security Number:	Date of Birth:

Dependent Child's Data:

Name:	Relationship to Insured:
Social Security Number:	Date of Birth:
Dependent's Address :	

Father:

Name:	Date of Birth:

Mother:

Name:	Date of Birth:

If Dependent Child is 18 or older, please complete:

Is Dependent Employed?	Does Dependent have Insurance through employment?
Is Dependent Married?	Does Dependent's Spouse have insurance coverage for the above dependent?

Dependent's Other Insurance **(Include a copy of the other insurance ID cards)**

Does your dependent have other Group Medical Coverage? ☐Yes ☐No	If yes, is the coverage type: ◯Single or ◯Family	Policy Coverages: ☐Medical ☐Pharmacy ☐Dental ☐Vision
Policyholder's Name:	Policyholder's DOB:	
Medical Insurance Carrier Name: Insurance Carrier Phone Number:	ID #:	Group #:
Policy Effective Date:	Policy Term Date (If applicable):	
Policyholder's Relationship To Dependent:	Policyholder's Employer: (if applicable)	

Include a copy of the certificate of creditable coverage for each person terminated on another healthcare insurance policy.

Is there legal documentation stating who is responsible for carrying the healthcare coverage for you or your dependents? ◯Yes ◯No **If yes, legal documents stating who is responsible for carrying healthcare coverage must accompany the form.**
Custodial Parents Name:
Custodial Parents Address:

INSURED'S SIGNATURE: _____ DATE: _____

DEPENDENT'S SIGNATURE: _____ DATE: _____
(If Dependent Child is 18 or older)

*Certificates must be copies of an official state or county issued document.