# SHEET METAL LOCAL 7 ZONE 2 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 ____________________ Date of Birth____________________

Do you have a **SOCIAL SECURITY DISABILITY AWARD**? _____NO _____YES
**If yes – submit a copy of your Social Security Disability Award along with this form**

**Please provide your Medicare insurance information**

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card

- OR -

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A and Part B

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name ____________________

Medicare Claim Number Sex ☐ M ☐ F

___ ___ ___ - ___ ___ - ___ ___ ___ ___ ___

Is Entitled To: Effective Date

**HOSPITAL (Part A)** ____________

**MEDICAL (Part B)** ____________

**▲This is for YOUR Medicare Information▲**

**If you do not have Medicare – are you "eligible" to enroll in 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
**If yes – submit a copy of your Social Security Disability Award along with this form**

**Please provide your Medicare insurance information**

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card

- OR -

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A and Part B

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name ____________________

Medicare Claim Number Sex ☐ M ☐ F

___ ___ ___ - ___ ___ - ___ ___ ___ ___ ___

Is Entitled To: Effective Date

**HOSPITAL (Part A)** ____________

**MEDICAL (Part B)** ____________

**▲This is for your SPOUSE'S Medicare Information▲**

**If your spouse does not have Medicare – is he/she "eligible" to enroll in Medicare?**

_______NO _________ YES

Do you have any eligible dependent children that should be covered under the Millwrights Local 1102 Health & Welfare Fund? ________NO ________YES

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

| Dependent Name | Date of Birth | Social Security Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

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

Daytime telephone number where you can be reached: ______________________________

(Please include area code)

Please mail your completed form to:

SHEET METAL WORKERS LOCAL 7 ZONE 2 HEALTH & WELFARE FUND
6525 Centurion Drive
Lansing, MI 48917
(888) 228-6700