

**MICHIGAN BAC**  
**HEALTH CARE FUND - GROUP 58034-000**  
 Managed for the Trustees by: TIC INTERNATIONAL CORPORATION  
**BLUE CROSS BLUE SHIELD OF MICHIGAN (BCBSM) ENROLLMENT FORM &**  
**YEARLY COORDINATION OF BENEFITS AND DEPENDENT STATUS STATEMENT**  
 (Please Type or Print Clearly)

Participant's Name Birthdate: Member ID or Social Security Number Telephone number

Address:

**Marital Status (check box to right of selection):** **Married** **Single** **Divorced** **Widowed** **Separated**

Spouse's Name Birthdate Social Security No.

Dependent's Name Relationship Birthdate Social Security No.

**FAMILY CONTINUATION COVERAGE - NOTE: PLEASE LIST ALL ELIGIBLE DEPENDENT CHILDREN AGE 19 OR OVER ON REVERSE SIDE.**

Are you or your dependents covered by any other medical insurance? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.

Check one: Yes No If Yes, please complete the section below:

Type of policy (check one): Group Individual

Name of Other Insurance Telephone number

Address of Other Insurance

Policy Number Group Number Policyholder's Name

Family Members Covered under the Policy

Are you or your dependents covered by any other dental insurance?

Check one: Yes No If Yes, please complete the section below:

Is this policy (Circle One) Group Individual

Name of Other Insurance Telephone number

Address of Other Insurance

Policy Number Group Number Policyholder's Name

Family Members Covered under the Policy

Are you or your dependents covered by any other vision insurance?

Check one: Yes No If Yes, please complete the section below:

Is this policy (Circle One) Group Individual

Name of Other Insurance Telephone number

Address of Other Insurance

Policy Number Group Number Policyholder's Name

Family Members Covered under the Policy

**PLEASE READ CAREFULLY AND SIGN BELOW**

I hereby certify that the above statements are true and complete to the best of my knowledge and belief. I understand that if I intentionally falsify any of the above information, Medical claims may be denied and I may be subject to litigation by the Fund. I also understand that I must notify the Fund of any changes in the above information within 30 days of any change.

**Member's Signature:** **Date:**

**Spouse's Signature:** **Date:**

**Return this form to:**

**MI BAC Health Care Fund, 6525 Centurion Drive, Lansing, MI 48917-9275**