

Change in Family Status Form

Participant Contract No.

(You will find this number on your MCTWF and BCBS identification cards)

Michigan Conference of Teamsters Welfare Fund
2700 Trumbull Ave.
Detroit, Michigan 48216
313-964-2400



MCTWF requires immediate notification of individuals who are either new dependents or who are no longer dependents of yours. Failure to promptly notify MCTWF may result in the loss of coverage for new dependents and, in the case of former dependents, may result in recovery actions for benefits paid and the loss of right to COBRA continuation coverage.

Please complete, sign and return to MCTWF at the above address. You must include the appropriate documentation, as described below, to support the type of status change noted for each dependent. Additional information may be required upon request from MCTWF.

Dependent Status Change Information					
NAME OF DEPENDENT (LAST—FIRST—MIDDLE)	DATE OF BIRTH	TYPE OF STATUS CHANGE CODE	DATE OF STATUS CHANGE	RELATIONSHIP	SOC. SEC. NO. OF DEPENDENT
GROUP HEALTH PLAN OR GROUP HEALTH INSURANCE CARRIER - EFFECTIVE DATE (MM/DD/YY) or TERMINATION DATE (MM/DD/YY) - MEDICAL, DENTAL VISION (Circle all that apply)					
NAME OF DEPENDENT (LAST—FIRST—MIDDLE)	DATE OF BIRTH	TYPE OF STATUS CHANGE CODE	DATE OF STATUS CHANGE	RELATIONSHIP	SOC. SEC. NO. OF DEPENDENT
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<u>Code</u>	<u>Type of Status Change</u>	<u>Required Documentation</u>
1	Marriage	Marriage Certificate
2	Adding step children	Marriage Certificate and portion of the finalized Judgment of Divorce, when applicable, that includes names of the parties, name of child(ren), who has custody and who has financial responsibility for the child(ren)'s health care expenses. Birth Certificate may be required.
3	Divorce	Finalized Judgment of Divorce - portion that includes names of the parties, names of children (if any), who has custody and who has financial responsibility for the child(ren)'s health care expenses
4	Death	Death Certificate
5	Birth	Birth Certificate
6	Adoption	Order of Adoption or Order Placing Child After Consent
7	Termination of spouse's insurance plan	Termination notification from spouse's group health, dental or vision insurance plan.
8	Spouse has new insurance plan	When adding spouse insurance information, additional documentation is not required.

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

Participant Name (please print)

Participant Signature

Date