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 beneficiaries or who are no longer beneficiaries of yours. Failure to promptly notify MCTWF may result in the loss of coverage for new beneficiaries and, in the case of former beneficiaries, 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, or fax to 313-748-4330, or email to documents@mctwf.org. You must include the appropriate documentation, as described below, to support the type of status change noted for each beneficiary. Additional information may be required upon request from MCTWF.

Beneficiary Status Change Information

NAME OF BENEFICIARY (LAST—FIRST—MIDDLE)	DATE OF BIRTH	TYPE OF STATUS CHANGE CODE	DATE OF STATUS CHANGE	RELATIONSHIP	GENDER	SOC. SEC. NO. OF BENEFICIARY

DEPENDENT IS ELIGIBLE FOR OTHER GROUP HEALTH PLAN COVERAGE ☐ YES ☐ NO
IF YES, NAME OF OTHER GROUP HEALTH PLAN | CARD HOLDER NAME & DATE OF BIRTH | EFFECTIVE DATE (MM/DD/YY) / / | MEDICAL, DENTAL VISION (Circle all that apply)

NAME OF BENEFICIARY (LAST—FIRST—MIDDLE)	DATE OF BIRTH	TYPE OF STATUS CHANGE CODE	DATE OF STATUS CHANGE	RELATIONSHIP	GENDER	SOC. SEC. NO. OF DEPENDENT

DEPENDENT IS ELIGIBLE FOR OTHER GROUP HEALTH PLAN COVERAGE ☐ YES ☐ NO
IF YES, NAME OF OTHER GROUP HEALTH PLAN | CARD HOLDER NAME & DATE OF BIRTH | EFFECTIVE DATE (MM/DD/YY) / / | MEDICAL, DENTAL VISION (Circle all that apply)

Code	Type of Status Change	Required Documentation
1	Marriage	Marriage Certificate
2	Adding step children	Marriage Certificate, Birth 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.
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.

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