Michigan Electrical Employees' Health Plan

6011 W. St. Joseph • Suite 401 • Lansing, MI 48917
517/323-9250 • 800/323-8943 (Michigan only)
www.meehp.com • Fax 517/323-1093

PARTICIPANT DATA FORM

(Incomplete or unsigned forms will not be processed and will be returned)

A. EMPLOYEE INFORMATION

SOCIAL SECURITY #	FULL LEGAL NAME (Last, First, Middle Initial)	BIRTH DATE	Office Use Only

STREET ADDRESS	CITY	STATE	ZIP CODE	MALE ____ FEMALE ____	HOME PHONE # ( )

MARITAL STATUS: SINGLE ___ MARRIED ____ (Date Married ________) DIVORCED___ (Date Divorced______)
WIDOW ___ SEPARATED_____ (Legally Separated/Separate Maintenance – Eff. Date _________)

HOME LOCAL # ______	WORK LOCAL # ______	CHECK ONE: BARGAINING EMPLOYEE ______ NON-BARGAINING EMPLOYEE ______

B. SPOUSE INFORMATION

SOCIAL SECURITY #	FULL LEGAL NAME (Last, First, Middle Initial)	BIRTH DATE	Office Use Only

IS SPOUSE EMPLOYED? YES _____ NO _____	EMPLOYER'S NAME	DOES SPOUSE HAVE OTHER INSURANCE? YES ___ NO ___ If yes, complete section "D" (on reverse)

C. DEPENDENT CHILD INFORMATION (Social Security # must be provided)

1. SOCIAL SECURITY #	FULL LEGAL NAME (Last, First, Middle Initial)*	BIRTH DATE	Office Use Only
MALE __ FEMALE __	DOES CHILD HAVE OTHER INSURANCE? YES ___ NO___ IS THIS CHILD A FULL TIME STUDENT? YES ___ NO___	If yes, complete section "D"	
2. SOCIAL SECURITY #	FULL LEGAL NAME (Last, First, Middle Initial)*	BIRTH DATE	Office Use Only
MALE __ FEMALE __	DOES CHILD HAVE OTHER INSURANCE? YES ___ NO___ IS THIS CHILD A FULL TIME STUDENT? YES ___ NO___	If yes, complete section "D"	
3. SOCIAL SECURITY #	FULL LEGAL NAME (Last, First, Middle Initial)*	BIRTH DATE	Office Use Only
MALE __ FEMALE __	DOES CHILD HAVE OTHER INSURANCE? YES ___ NO___ IS THIS CHILD A FULL TIME STUDENT? YES ___ NO___	If yes, complete section "D"	
4. SOCIAL SECURITY #	FULL LEGAL NAME (Last, First, Middle Initial)*	BIRTH DATE	Office Use Only
MALE __ FEMALE __	DOES CHILD HAVE OTHER INSURANCE? YES ___ NO___ IS THIS CHILD A FULL TIME STUDENT? YES ___ NO___	If yes, complete section "D"	
5. SOCIAL SECURITY #	FULL LEGAL NAME (Last, First, Middle Initial)*	BIRTH DATE	Office Use Only
MALE __ FEMALE __	DOES CHILD HAVE OTHER INSURANCE? YES ___ NO___ IS THIS CHILD A FULL TIME STUDENT? YES ___ NO___	If yes, complete section "D"	

*If you have named a dependent child whose birth parents are divorced or separated, a copy of the court order is required stating which parent is responsible for providing health insurance. **ATTACH COPY OF COMPLETE COURT ORDER UNLESS SENT PREVIOUSLY.**

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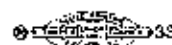

D. "OTHER" INSURANCE INFORMATION (PLEASE COMPLETE IN FULL)

EMPLOYEE NAME	EMPLOYER NAME: ADDRESS: CITY: STATE: ZIP: PHONE#:	
INSURANCE COMPANY NAME	ADDRESS	CITY/STATE/ZIP
POLICY #	EFFECTIVE DATE	PHONE #
PRESCRIPTION COVERAGE? YES ___ NO ___	VISION COVERAGE? YES ___ NO ___	
DENTAL COVERAGE? YES ___ NO ___	DEPENDENT COVERAGE? YES ___ NO ___	

LIST DEPENDENTS COVERED

E. MEDICARE INFORMATION

NAME	MEDICARE #	
REASON FOR COVERAGE: DISABLED ___ AGE 65 ___ ESRD ___ (OR OLDER)	PART A (HOSPITAL) EFFECTIVE DATE ___________	PART B (MEDICAL) EFFECTIVE DATE ___________

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any health care provider, insurance company, employer, person or organization to release any information regarding the medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable (including disability or employment-related information) to the Michigan Electrical Employees' Health Plan, its insurance company, administrator or their service providers or other authorized agents for the purpose of validating and determining benefits payable, cost management, pre-certification and claims services including reviews of claims paying practices. I also authorize the release of such information with regard to any of my minor children covered by the Plan. A copy of this authorization shall be as valid as an original.

I hereby certify that the foregoing statements are to the best of my knowledge and belief true, correct, and complete. I will reimburse the Plan for any overpayment made to me or in my behalf due to incorrect information on this form.

EMPLOYEE SIGNATURE **DATE**

SIGNATURE OF EMPLOYEE'S SPOUSE (if applicable) **DATE**