2010 Annual Information Update Form

Please return by December 15, 2009 to:
Mo-Kan Sheet Metals Workers Welfare Fund, P.O. Box 300019, Kansas City, MO 64130-0019
Phone Number: 816-531-0334 or Toll Free at 866-531-5488

I. ADDRESS VERIFICATION

**All correspondence will be mailed to the address listed below.

Member Name: _____ ___ DOB: _____ SSN: ____-____-_____

Address, City, State, Zip Code: _____

Telephone # _____ Email Address: _____

Local Number: _____ Employer: _____ Retired: Yes ☐ No ☐

If you are retired, are you receiving social security benefits due to a disability? Yes ☐ No ☐

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

II. PRIMARY INSURANCE INFORMATION

Does anyone in your family have any other insurance besides Mo-Kan? ☐ Yes ☐ No
If yes, please complete the following information:

	Spouse	Dependent	Dependent	Dependent
Name (First, Last)				
DOB				
SSN				
Gender				
Name of Other Insurance Carrier				
Policy Effective Date				
Other Carrier Phone Number				
Policy Holders Name/Relationship to Member				
Coverage Type (Please check all that apply)	☐ Medical ☐ Dental ☐ RX ☐ Vision ☐ HRA ☐ HSA	☐ Medical ☐ Dental ☐ RX ☐ Vision	☐ Medical ☐ Dental ☐ RX ☐ Vision	☐ Medical ☐ Dental ☐ RX ☐ Vision

III. WORKING SPOUSE COVERAGE INFORMATION (To be completed by the Spouse if applicable)

1) ☐ I am not employed.

2) ☐ I am employed. Name of Employer: _____

Employer Address: _____

Employer Phone #: _____

***Please note – 2010 claims will NOT be processed until this information is returned to Mo-Kan.**

Member Signature: _____ Date: _____