Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund

3001 Metro Drive – Suite 500 | Bloomington, MN 55425 | 952.851.5797 | 1.844.468.5917

Dear Participant:

Each calendar year it is necessary to update our records for this office. Please provide us with the following information in lieu of a claim form, for each member. During the year, you may also be required to complete a claim form(s) if a bill is received that appears to be accident related.

Insured's Data

Name:	Social Security Number:
Date of Birth:	Phone Number:
Address:	

Medicare Information including Medicare Part D - Prescription Drug Program

Your Name:_____ Date of Birth _____ /_____ /_____ Medicare HIC #: _____

Effective Date: Part A: _____ /_____ /_____ Part B: _____ /_____ /_____ Part D: _____ /_____ /_____

If you are retired, please indicate retirement date: You: _____ /_____ /_____

Do you have Medicare due to:
☐End-stage renal disease and/or ☐disability ? Effective Date: _____ /_____ /_____

We are pleased to be of service to you. Please contact this office if you have any questions.

Please sign below, verifying that the above statements are true to the best of your knowledge and belief. Your Signature will also authorize an institution or physician to release information concerning your enrollment, related records and medical records to the fund office, if needed.

_____ _____

Participant's Signature *Date of Signature*