

OPERATING ENGINEERS TRUST FUNDS

I.U.O.E. LOCAL 12 HEALTH & WELFARE / PENSION / VACATION / TRAINING

100 EAST CORSON STREET • PASADENA, CALIFORNIA 91103 • (626) 356-1000

P.O. BOX 7063, PASADENA, CALIFORNIA, 91109



ENROLLMENT IN THE PLAN

Please complete the enclosed **Health Plan Enrollment Form** and return it to the Fund Office as soon as possible. You must list any dependents to be covered by the Plan. If your dependents later change due to marriage, divorce, birth or adoption, you must complete and submit a new Health Plan Enrollment Form. If you or any of your dependents are covered under another group health plan (such as a spouse's plan), you must also complete and return a **Group Insurance Questionnaire**.

All of these forms are available to download and print from the Fund's website at:
<http://www.oefunds.org/forms/forms1.htm>

Dependent Requirements

If You Want To:	Documentation Required by the Plan
Add a new dependent spouse	Certified copy of the recorded marriage certificate.
Remove a divorced spouse	Copy of the recorded final divorce decree.
Add your dependent child	Certified copy of the recorded birth certificate. <i>Note:</i> To qualify as an eligible dependent, the child must be unmarried and live with you . If the child does not live with you, the Plan will require a Qualified Medical Child Support Order (QMCSO) that designates one parent to pay for the child's health coverage and meets all of the federal requirements for a QMCSO. If you are adding a stepchild, please contact the Fund Office as there are special requirements.
Add a foster child, adopted child or a child for whom you are the legal guardian	Copies of the recorded birth certificate and legal documentation (e.g. adoption or guardianship papers issued by the court).
Add dependents age 19 to 26	Certified copy of the recorded birth certificate and verification of full-time student status from an accredited school. <i>Note:</i> To qualify as an eligible dependent, the child must be unmarried and live with you (or at school).

Failure to complete these forms when required may delay payment of claims for your dependents. Claims will not be paid for any new dependent until the Fund Office has received all required enrollment forms and documents. (Note: Social Security Numbers are required on the form for you and all dependents.)

HEALTH PLAN ENROLLMENT FORM

Note: This form must be completed in full and signed by the Participant before it will be accepted as a valid record.

PARTICIPANT INFORMATION

Social Security Number	Last Name	First Name	Middle	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address		City	State	ZIP Code	Home Phone # () _____ Daytime Phone # () _____
Marital Status (Check One): <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		Date of Marriage	Date of Divorce	Spouse Date of Death	SOCIAL SECURITY NUMBER FOR YOU AND ALL OF YOUR DEPENDENTS MUST BE PROVIDED.
Are you covered by any other health plan as a participant or dependent? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, you must complete the Group Insurance Questionnaire)				Medicare eligible? <input type="checkbox"/> No <input type="checkbox"/> Yes (see below)	
E-mail address:				Medicare-entitled due to: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease Please return a copy of your Medicare card with this form.	

SPOUSE INFORMATION

Social Security Number	Last Name of Spouse	First Name of Spouse	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Mailing Address (with City, State & ZIP) – if different from participant’s				
Name of Spouse’s Employer (if any):		Address of Spouse’s Employer (if applicable)		
Is this spouse covered by any other health plan as a participant or dependent? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, you must complete the Group Insurance Questionnaire)				Medicare eligible? <input type="checkbox"/> No <input type="checkbox"/> Yes (see below)
				Medicare-entitled due to: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease Please return a copy of your Medicare card with this form.

DEPENDENT CHILD INFORMATION

Social Security Number	Last Name of Child	First Name of Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	
Mailing Address (with City, State & ZIP) – if different from participant’s					
Child is my: <input type="checkbox"/> Natural <input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Other: <input type="checkbox"/> Adopted		Medicare eligible? <input type="checkbox"/> No <input type="checkbox"/> Yes (see below) Medicare-entitled due to: <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease	Is this child covered by any other health plan as a participant or dependent? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, you must complete the Group Insurance Questionnaire)		

Social Security Number	Last Name of Child	First Name of Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	
Mailing Address (with City, State & ZIP) – if different from participant’s					
Child is my: <input type="checkbox"/> Natural <input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Other: <input type="checkbox"/> Adopted		Medicare eligible? <input type="checkbox"/> No <input type="checkbox"/> Yes (see below) Medicare-entitled due to: <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease	Is this child covered by any other health plan as a participant or dependent? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, you must complete the Group Insurance Questionnaire)		

Social Security Number	Last Name of Child	First Name of Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	
Mailing Address (with City, State & ZIP) – if different from participant’s					
Child is my: <input type="checkbox"/> Natural <input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Other: <input type="checkbox"/> Adopted		Medicare eligible? <input type="checkbox"/> No <input type="checkbox"/> Yes (see below) Medicare-entitled due to: <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease	Is this child covered by any other health plan as a participant or dependent? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, you must complete the Group Insurance Questionnaire)		

(If you have more dependent children, please continue on the next page.)

I certify under penalty of perjury that to the best of my knowledge all information provided on this document is true, correct and complete.

Signature of Participant Required	Date
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HEALTH PLAN ENROLLMENT FORM

(Page Two)

List additional dependent children below:

DEPENDENT CHILD INFORMATION				
Social Security Number	Last Name of Child	First Name of Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Mailing Address (with City, State & ZIP) – if different from participant’s				
Child is my: <input type="checkbox"/> Natural <input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Other: <input type="checkbox"/> Adopted _____	Medicare eligible? <input type="checkbox"/> No <input type="checkbox"/> Yes (see below) Medicare-entitled due to: <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease	Is this child covered by any other health plan as a participant or dependent? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, you must complete the Group Insurance Questionnaire)		
Social Security Number	Last Name of Child	First Name of Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Mailing Address (with City, State & ZIP) – if different from participant’s				
Child is my: <input type="checkbox"/> Natural <input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Other: <input type="checkbox"/> Adopted _____	Medicare eligible? <input type="checkbox"/> No <input type="checkbox"/> Yes (see below) Medicare-entitled due to: <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease	Is this child covered by any other health plan as a participant or dependent? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, you must complete the Group Insurance Questionnaire)		
Social Security Number	Last Name of Child	First Name of Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Mailing Address (with City, State & ZIP) – if different from participant’s				
Child is my: <input type="checkbox"/> Natural <input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Other: <input type="checkbox"/> Adopted _____	Medicare eligible? <input type="checkbox"/> No <input type="checkbox"/> Yes (see below) Medicare-entitled due to: <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease	Is this child covered by any other health plan as a participant or dependent? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, you must complete the Group Insurance Questionnaire)		
Social Security Number	Last Name of Child	First Name of Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Mailing Address (with City, State & ZIP) – if different from participant’s				
Child is my: <input type="checkbox"/> Natural <input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Other: <input type="checkbox"/> Adopted _____	Medicare eligible? <input type="checkbox"/> No <input type="checkbox"/> Yes (see below) Medicare-entitled due to: <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease	Is this child covered by any other health plan as a participant or dependent? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, you must complete the Group Insurance Questionnaire)		
Social Security Number	Last Name of Child	First Name of Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Mailing Address (with City, State & ZIP) – if different from participant’s				
Child is my: <input type="checkbox"/> Natural <input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Other: <input type="checkbox"/> Adopted _____	Medicare eligible? <input type="checkbox"/> No <input type="checkbox"/> Yes (see below) Medicare-entitled due to: <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease	Is this child covered by any other health plan as a participant or dependent? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, you must complete the Group Insurance Questionnaire)		

Please return form to: Operating Engineers Health & Welfare Fund, PO Box 7067, Pasadena, CA 91109