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
WEBSITE: www.oefunds.org

November 17, 2009

Dear Participant,

Enclosed is Open Enrollment information for the Widow Health & Welfare Plan. Please read this information carefully. If you wish to enroll in the Plan at this time, you must complete the enclosed form and return it to the Fund Office no later than December 31, 2009.

Important: Widows or widowers who have remarried or who have group health insurance (other than Medicare) through employment do not qualify for re-enrollment in the Plan.

The current monthly fees are on the following page and are subject to change at any time by action of the Board of Trustees.

If you decide to enroll in the plan at this time, you must pay the monthly fees for January, February and March, 2010, but your coverage will not begin until April 1, 2010. Any medical or dental expenses you incur prior to April 1, 2010, will not be covered.

Please return the enclosed form with your personal check or money order to cover the three-month period of January through March, 2010. Your next payment will be due on or before April 1, 2010.

Shortly after April 1, 2010, you will receive an identification card and a packet of information about the Plan. Please get in touch with the Information Center at (888) 512-5279 or (626) 356-1004 if you have any questions.

BOARD OF TRUSTEES

Operating Engineers Health & Welfare Fund

-OVER-

OPEN ENROLLMENT FORM – WIDOW PLAN

PLEASE COMPLETE ALL OF THE REQUESTED INFORMATION
AND RETURN THE ENTIRE PAGE TO THE FUND OFFICE.

WIDOW'S NAME: ________________________ WIDOW'S SOC. SEC. # or OEID#: _________________________

ADDRESS: ____

CITY: ____STATE: ______________ZIP CODE: __________________

PHONE NUMBER: (   ) ________________________________

MEMBER'S NAME: _________________________________MEMBER'S SOC. SEC.#:________________________

1. I DO NOT want to participate in the Widow Plan at this time.

2. I want to participate in the Widow Plan and I would like the Fund to cover the following family members on April 1, 2010. Include yourself if you want to be covered.

Name	Date of Birth	Social Security Number	Have Medicare? (If yes, enclose copy of Medicare card.)		Plan Selected Option (See attached; select one)		
					"A"	"B"	"C"
			YES	NO			
			YES	NO			
			YES	NO			

3. My monthly fee for the Widow Health & Welfare coverage will be: $____________________

4. I prefer:

Monthly payments by personal check or money order	Automatic deduction from my Operating Engineers pension check

5. If you are currently working at any job, please provide the following information:

Your Employer's Name	Your Employer's Phone Number

Group Insurance Name	Group Insurance Address	Group Insurance Phone Number

I understand that I can withdraw and revoke this authorization by written notice to the Fund Office.

DATE:______________________________ SIGNATURE____

This form is not a guarantee of eligibility in the Plan. Your eligibility in the Plan will be determined during the processing of your application.

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

WIDOW AND DEPENDENT HEALTH & WELFARE MONTHLY FEES

(Subject to change at any time by action of Board of Trustees)

	Option "A" Full Fee-for-Service Plan This is the CURRENT plan, which covers hospital, medical (secondary to Medicare, if applicable), Rx drugs, dental, vision & hearing aids (all of the current Plan benefits).	Option "B" HMO Medical & Dental Plan You must enroll in one of the Plan's HMOs (Kaiser, Health Net, Health Plan of NV) & DeltaPMI's dental HMO plan. ALL medical and dental care must be obtained through these HMOs. The Fund will pay only the fees to the HMOs.	Option "C" Limited Coverage Plan You may obtain your medical & hospital coverage elsewhere (e.g., Medicare, your spouse's health plan, etc...) at your own cost, if any. The Fund would pay ONLY for Rx drugs, dental, vision, & hearing aids.
Single Coverage (No dependents):			
If you have Medicare	$145	$113	$ 76
If you DO NOT have Medicare	$263	$188	$ 76
Two-Party Coverage (Two family members):			
If ONE has Medicare	$408	$301	$152
If both DO NOT have Medicare	$526	$376	$152
Family Coverage (3 or more family members):			
If One has Medicare	$540	$395	$190
If NO ONE has Medicare	$658	$470	$190