OPERATING ENGINEERS TRUST FUNDS

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

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P.O. BOX 7063, PASADENA, CALIFORNIA 91109
TTY: (626) 356-3582 WEBSITE: www.oefi.org

Group Insurance Questionnaire

Participant or Beneficiary Information			
Social Security Number/OE ID	Last Name	First Name	Middle Initial

Address Information			
Street Address			
City		State	ZIP Code
Home Phone Number ( )	Mobile Phone Number ( )	Email Address	
Are you covered by any other health plan as a participant or dependent? ☐ No ☐ Yes (If yes, please answer the following questions)		**Social Security Number for you and all your dependents must be provided.**	
Name of Employer who provides this coverage	Employer's Address	Employer's Phone	

Are you also covered by Medicare? (Please attach a copy of your Medicare card when you return this form.)

☐ No ☐ Yes (If yes, please provide the effective date of your Medicare coverage _____/_____/_____

Other Medical Insurance – Important: Please attach a copy of your other insurance card when you return this form.			
Name of Medical Insurance Carrier	Medical Insurance Carrier's Address	Insurance Carrier's Phone Number	
Policy Number	Effective Date _____/_____/_____	Type of Policy ☐ Group ☐ Private ☐ Retiree Plan	Type of Medical Plan ☐ HMO ☐ PPO ☐ EPO ☐ POS

List your dependents who are covered by this medical policy:		
Name	Social Security Number	If a step-child, who is the custodial parent?
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Other Dental Insurance – Important: Please attach a copy of your other insurance card when you return this form.			
Name of Dental Insurance Carrier	Dental Insurance Carrier's Address	Insurance Carrier's Phone Number	
Policy Number	Effective Date _____/_____/_____	Type of Policy ☐ Group ☐ Private ☐ Retiree Plan	Type of Dental Plan ☐ DHMO ☐ DPPO ☐ EPO ☐ POS

List your dependents who are covered by this dental policy:		
Name	Social Security Number	If a step-child, who is the custodial parent?
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Name	Social Security Number	If a step-child, who is the custodial parent?
Name	Social Security Number	If a step-child, who is the custodial parent?
Name	Social Security Number	If a step-child, who is the custodial parent?

Spouse Information (see other side for participant information)

Social Security Number	Last Name	First Name	Middle Initial

Address Information

Street Address			
City		State	ZIP Code
Home Phone Number ( )	Mobile Phone Number ( )	Email Address	

Is **your spouse** covered by any other health plan as a participant or dependent?

☐ No ☐ Yes (If yes, please answer the following questions)

Social Security Number for you and all your dependents must be provided.

Name of Employer who provides this coverage	Employer's Address	Employer's Phone

Is **your spouse** covered by Medicare? (Please attach a copy of your spouse's Medicare card when you return this form.)

☐ No ☐ Yes (If yes, please provide the effective date of your spouse's Medicare coverage _____/_____/_____

Other Medical Insurance – Important: Please attach a copy of your spouse's other insurance card when you return this form.

Name of Medical Insurance Carrier	Medical Insurance Carrier's Address	Insurance Carrier's Phone Number

Policy Number	Effective Date	Type of Policy	Type of Medical Plan
	_____/_____/_____	☐ Group ☐ Private ☐ Retiree Plan	☐ HMO ☐ PPO ☐ EPO ☐ POS

List your dependents who are covered by this medical policy:

Name	Social Security Number	If a step-child, who is the custodial parent?
Name	Social Security Number	If a step-child, who is the custodial parent?
Name	Social Security Number	If a step-child, who is the custodial parent?
Name	Social Security Number	If a step-child, who is the custodial parent?

Other Dental Insurance – Important: Please attach a copy of your spouse's other insurance card when you return this form.

Name of Dental Insurance Carrier	Dental Insurance Carrier's Address	Insurance Carrier's Phone Number

Policy Number	Effective Date	Type of Policy	Type of Medical Plan
	_____/_____/_____	☐ Group ☐ Private ☐ Retiree Plan	☐ DHMO ☐ DPPO ☐ EPO ☐ POS

List your dependents who are covered by this dental policy:

Name	Social Security Number	If a step-child, who is the custodial parent?
Name	Social Security Number	If a step-child, who is the custodial parent?
Name	Social Security Number	If a step-child, who is the custodial parent?
Name	Social Security Number	If a step-child, who is the custodial parent?

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

Participant's Signature (Required)

X	Date _____/_____/_____

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