

OPERATING ENGINEERS TRUST FUNDS

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

100 CORSON STREET, SUITE 100 • PASADENA, CALIFORNIA 91103 • (866) 400-5200

P.O. BOX 7063, PASADENA, CALIFORNIA 91109

TTY: (626) 356-3582 WEBSITE: www.oefi.org



PLAN ENROLLMENT

New federal laws require the Fund to collect enrollment information on all Plan participants. Please complete the enclosed **Health Plan Enrollment Form** and return it to the Fund Office as soon as possible. You must list any dependents 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 Medicare or a spouse's), you must also complete and return a **Group Insurance Questionnaire**.

This information will assist the Health & Welfare Fund in complying with these federal laws.

Note: Claims will not be paid for any new dependent until the Fund Office has received all required enrollment forms and documents. (**Social Security Numbers are required** on the form for you and all dependents.)

Dependent Requirements

If You Want To:	Documentation Required by the Plan
Add a new dependent spouse	Certified marriage certificate.
Remove a divorced spouse	Copy of the recorded final divorce decree.
Add your dependent child under age 19	Certified birth certificate.
Add a foster child, adopted child or a child for whom you are the legal guardian	Certified birth certificate and legal documentation (e.g. adoption or guardianship papers issued by the court).
Add your dependent child age 19 to 26	<p>Certified birth certificate and completion of the Young Adult Enrollment Affidavit.</p> <p>A Young Adult's spouse and children are not eligible to enroll in this Plan.</p>

All of these forms are available to download and print from the Fund's website at:

<http://www.oefi.org>

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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 (Local 12 Member) Information				
Social Security Number/OE ID	Last Name	First Name	Middle	
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone # () _____	Mobile Phone # () _____	
Street Address				
City			State	ZIP Code
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)		
		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)		

List additional dependent children below:

Dependent Child Information (Continued)				
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)
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				
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