OPERATING ENGINEERS LOCAL 99 & 99A HEALTH & WELFARE FUND

3615 NORTH POINT BLVD – SUITE C – BALTIMORE MD 21222
(410) 254-9595 / 1(800) 367-7848 Fax: (410) 254-2016 – Attn: Registration

ENROLLMENT IN THE PLAN

IMPORTANT INFORMATION – PLEASE READ

Please complete the enclosed **Health Plan Enrollment Form** and return it to the Fund Office **WITHIN 30 DAYS. DO NOT DELAY:** this form must be completed when you are hired, have a change in family status or changing your address. You must list any dependents to be covered by the Plan even if you are just changing your address. 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 **Benefit Inquiry Questionnaire.** If you move please notify the Fund Office of your new address. Please note, Part-Time Employees are not eligible for Health benefits. **Please return all required documents with your Health Enrollment Form.**

Dependent Requirements

If You Want To:	Documentation Required by the Plan (All Document must be Translated in English)
Add a new dependent spouse	Certified copies of the recorded Marriage Certificate and recorded Birth Certificate.
Adding Newborn children	Certificate of Live Birth/Registration from the Hospital with the Policy Holder's Name on the Certificate
Remove a divorced spouse	Copy of the recorded final divorce decree.
Add your dependent child under 26 years of age	Certified copy of the recorded Birth Certificate. Policy Holder's Name must be on the Certificate. If you are adding a stepchild, copies of recorded Birth Certificate and legal documentation (e.g. guardianship papers or Adoption papers issued by the Court).
Add 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).

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. (Social Security Numbers are required on the form for you and all dependents.) **You can now email your completed forms and documents. Please go to our Website at www.dsibenefitfund.org, click on Member Services and select Registration Documents. Then click on Registration – Document Upload Form and follow the instruction to submit your documents to a Secure Website.**

OPERATING ENGINEERS LOCAL 99 & 99A
HEALTH & WELFARE FUND

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	☐ Male ☐ Female

Mailing Address	City	State	Zip	Home Phone: ( ) - Cell Phone: ( ) -

Martial Status (check one) ☐ Married ☐ Single ☐ Widowed ☐ Divorced	Date of Marriage / /	Date of Divorce / /	Spouse Date of Death / /	Current Employer: Date of Hire:

Are you covered by any other Health Plan as a participant or dependent? ☐ No ☐ Yes (if yes, you must complete the Benefit Inquiry Questionnaire)	Are You Eligible for Medicare? ☐ No ☐ Yes
E-Mail Address: **Date of Retirement**	**Medicare Entitlement Due to:** ☐ Age ☐ Disability ☐ Renal Disease
TYPE OF COVERAGE: ☐ SINGLE ☐ FAMILY ☐ PART-TIME	**Please Return a Copy of Your Medicare Card Front & Back with this form.**

SPOUSE INFORMATION

PLEASE ATTACH COPIES OF: Social Security Card - Marriage Certificate - Birth Certificate

Social Security Number	Last Name of Spouse	First Name of Spouse	Middle	Date of Birth	☐ Male ☐ Female

Mailing Address - City-State-Zip (if different from participant's)

Name of Spouse's Employer (if any)	Address of Spouse's Employer (if applicable)

Is the Spouse covered by any other Health Plan as a participant or dependent? ☐ No ☐ Yes (if yes, you must complete the Benefit Inquiry Questionnaire)	Are You Eligible for Medicare? ☐ No ☐ Yes
Spouse's E-Mail Address (if applicable) **Date of Retirement**	**Medicare Entitlement Due to:** ☐ Age ☐ Disability ☐ Renal Disease
(if different from participant) Home Phone: ( )_____-_____ Cell Phone: ( )_____-_____	**Please Return a Copy of Your Medicare Card Front & Back with this form.**

DEPENDENT CHILD INFORMATION

PLEASE ATTACH COPIES OF: Social Security Card - Birth Certificate - Adoption or Legal Guardianship papers issued by the Court, if applicable

Social Security Number	Last Name of Child	First Name of Child	Middle	Date of Birth	☐ Male ☐ Female

Mailing Address - City-State-Zip (if different from participant's)

Relationship to Participant ☐ Natural ☐ Foster ☐ Step ☐ Other ☐ Adopted _____	Are You Eligible for Medicare? ☐ No ☐ Yes Medicare Entitlement Due to: ☐ Disability ☐ Renal Disease	Is the Child covered by any other Health Plan as a participant or Dependent? ☐ No ☐ Yes (if yes, you must complete the Benefit Inquiry Questionnaire)

I authorize the release to and use by O.E. LOCAL 99 & 99A BENEFIT FUND of any medical or other information that may be required to establish the validity of any claim for benefits for myself or on behalf of my insured dependents.

I CERTIFY THAT I HAVE READ THIS FORM & VERIFY THAT ANY INFORMATION PROVIDED BY ME IS CORRECT.

Date Signed: _____ **Member's Signature:** _____

PLEASE RETURN FORM TO: IUOE Local 99 & 99A - Attn: Health & Welfare Fund - 2461 Wisconsin Avenue-Washington DC 20007-1862

OPERATING ENGINEERS LOCAL 99 & 99A
HEALTH & WELFARE FUND

HEALTH PLAN ENROLLMENT FORM
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Participant's Name: ______________________

Participant's Social Security # ______________________

List Additional Dependent Children Below:

DEPENDENT CHILD INFORMATION

PLEASE ATTACH COPIES OF: Social Security Card - Birth Certificate - Adoption or Legal Guardianship papers issued by the Court, if applicable

Social Security Number	Last Name of Child	First Name of Child	Middle	Date of Birth	☐ Male ☐ Female
Mailing Address - City-State-Zip (if different from participant's)					
Relationship to Participant ☐ Natural ☐ Foster ☐ Step ☐ Other ☐ Adopted ______	Are You Eligible for Medicare? ☐ No ☐ Yes Medicare Entitlement Due to: ☐ Disability ☐ Renal Disease		Is the Child covered by any other Health Plan as a participant or Dependent? ☐ No ☐ Yes (if yes, you must complete the Benefit Inquiry Questionnaire)		

DEPENDENT CHILD INFORMATION

Social Security Number	Last Name of Child	First Name of Child	Middle	Date of Birth	☐ Male ☐ Female
Mailing Address - City-State-Zip (if different from participant's)					
Relationship to Participant ☐ Natural ☐ Foster ☐ Step ☐ Other ☐ Adopted ______	Are You Eligible for Medicare? ☐ No ☐ Yes Medicare Entitlement Due to: ☐ Disability ☐ Renal Disease		Is the Child covered by any other Health Plan as a participant or Dependent? ☐ No ☐ Yes (if yes, you must complete the Benefit Inquiry Questionnaire)		

DEPENDENT CHILD INFORMATION

Social Security Number	Last Name of Child	First Name of Child	Middle	Date of Birth	☐ Male ☐ Female
Mailing Address - City-State-Zip (if different from participant's)					
Relationship to Participant ☐ Natural ☐ Foster ☐ Step ☐ Other ☐ Adopted ______	Are You Eligible for Medicare? ☐ No ☐ Yes Medicare Entitlement Due to: ☐ Disability ☐ Renal Disease		Is the Child covered by any other Health Plan as a participant or Dependent? ☐ No ☐ Yes (if yes, you must complete the Benefit Inquiry Questionnaire)		

DEPENDENT CHILD INFORMATION

Social Security Number	Last Name of Child	First Name of Child	Middle	Date of Birth	☐ Male ☐ Female
Mailing Address - City-State-Zip (if different from participant's)					
Relationship to Participant ☐ Natural ☐ Foster ☐ Step ☐ Other ☐ Adopted ______	Are You Eligible for Medicare? ☐ No ☐ Yes Medicare Entitlement Due to: ☐ Disability ☐ Renal Disease		Is the Child covered by any other Health Plan as a participant or Dependent? ☐ No ☐ Yes (if yes, you must complete the Benefit Inquiry Questionnaire)		

If you have any questions about what documents are required to add dependents, please contact the Benefit Fund at (410) 254-9595 or 1(800) 367-7848. If additional space is needed, please make a copy of this form.

I CERTIFY THAT I HAVE READ THIS FORM & VERIFY THAT ANY INFORMATION PROVIDED BY ME IS CORRECT.

Date Signed: ______________ **Member's Signature:** ______________________

PLEASE RETURN FORM TO: IUOE Local 99 & 99A - Attn: Health & Welfare Fund - 2461 Wisconsin Avenue-Washington DC 20007-1862