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 <u>WITHIN 30 DAYS</u>. **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

	Depondent 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 <u>all</u> 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

		PAF	RTICIPA	NI INFO					
ocial Security Number	Last Name	ar a	First Name		Middle	Date of Birth		□ Male	□ Female
ailing Address			City		State	Zip	Home Phone:	()	_
						-	2	()	-
untial Status (abank ann)	Date of Marriage	Date of Divorce	Spouse Date of			*	Cell Phone:	()	
rtial Status (check one) ☐ Married ☐ Single			Death	Currer	urrent Employer:				
☐ Widowed ☐ Divorced	1 1	1 1	1 1	1	Date of Hire):			,
re you covered by any	other Health Pla	an as a partic	ipant or depe	ndent?		Are You Elig	gible for Medic	care?	
No □ Yes (if	ves vou must com	nlete the Benefit	Inquiry Question	nnaire)		□ No	□ Yes		
□ No □ Yes (if yes, you must complete the Benefit Inquiry Question E-Mail Address:			inquity Quoditor	Date of Retirement			ntitlement Due	to:	
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TYPE	OF COVE	RAGE:				Please Return a Copy of Your Med			Medicare
□ SINGLE	□ FAMILY	□ PART-T	IME	9		Card From	ith this fo	rm.	
			SPOUSE	INFOR	MATIO	N			
PLEASE	ATTACH CO	OPIES OF:	Social Se	curity Card	l - Marria	ge Certifica	ate - Birth	Certificat	е
ocial Security Number	Last Name of Spo	ouse	First Name of Sp	ouse	Middle	Date of Birth		□ Male	□ Female
iling Address - City-State-Zip	(if different from par	ticipant's)	L						
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ame of Spouse's Employer (if a	any)		Address of Spou	se's Employer (if	аррисавіе)				
the Spouse covered b	y any other Hea	alth Plan as a	participant o	r dependent?		Are You Elig	gible for Medic	care?	
□ No □ Yes (if	yes, you must com	plete the Benefit	t Inquiry Question	nnaire)		□ No	□ Yes		
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PLEASE ATTACH poial Security Number ailling Address - City-State-Zip Relationship to Participant Natural □ Foster	Cell Phone: COPIES OF Last Name of Chi (if different from par Are You Eligi No Medicare Enter	ticipant's) ible for Medic	Security Ca issued by t First Name of Ch	rd - Birth (he Court, i	Certificate f applicab Middle Middle	ATION - Adoption le Date	or Legal Go	uardiansh □ Male th Plan as a	□ Female

Date Signed:	Member's Signature:	x = 2 =	-

OPERATING ENGINEERS LOCAL 99 & 99A HEALTH & WELFARE FUND

HEALTH PLAN ENROLLMENT FORM PAGE 2

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Participant's Name:		,						
Participant's Social Se	curity #		9 8					
List Additional De	ependent Childrer	Below:	2					
	DEPE	NDENT CHILD	INFORM	ATION				
PLEASE ATTACH	COPIES OF: Social				or Legal G	uardians	hip papers	
		issued by the Court,						
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)	9	e v	v				
	Are You Eligible for Medic	Is the Child covered by any other Health Plan as a participant						
Relationship to Participant □ Natural □ Foster	□ No □ Yes		Dependent?					
□ Step □ Other	Medicare Entitlement Due	to	-		(if yes you	u must complete the		
□ Adopted	□ Disability	□ Renal Disease	□ No	□ Yes	Benefit Inc			
		NDENT CHILD	INFORM	ATION	Deficit inc	diry Gac	otionnaire)	
Social Security Number	Last Name of Child	First Name of Child	Middle		of Birth	□ Male	□ Female	
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maining Address - Oity-State-Zip (ii	unierent nom participant sj							
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Relationship to Participant	Are You Eligible for Medic	care?	1	covered by a	ny other Healt	h Plan as a	participant or	
□ Natural □ Foster	□ No □ Yes		Dependent?					
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□ Adopted	□ Disability	□ Renal Disease	□ No	□ Yes	Benefit Inc			
	DEF	ENDENT CHILD	INFORMA"	TION				
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Mailing Address - City-State-Zip (if	 different from participant's			-		L		
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Relationship to Participant	Are You Eligible for Medic	aler	Dependent?	covered by a	ny other nean	.II FIAII 45 6	i participant of	
□ Natural □ Foster	□ No □ Yes							
□ Step □ Other	Medicare Entitlement Due	to:	□ No	□ Yes	(if yes, you	ı must co	ust complete the	
□ Adopted	□ Disability	□ Renal Disease		2 300 10 1000000	Benefit Inc	uiry Ques	stionnaire)	
	DEF	ENDENT CHILD	INFORMAT	TION				
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	2							
Mailing Address - City-State-Zip (it	f different from participant's)						7.0, 10.000	
	Are You Eligible for Medic	care?	Is the Child of	overed by a	ny other Healt	h Plan as a	participant or	
Relationship to Participant	W 90		Dependent?					
□ Natural □ Foster	□ No □ Yes		_					
□ Step □ Other	Medicare Entitlement Due		□ No	□ Yes	(if yes, you			
□ Adopted	□ Disability	□ Renal Disease			Benefit Inc	ury Que	stionnaire)	
Id bassa				142 14	dan andr	.4		
	uestions about w		•					
contact the Bene	fit Fund at (410) 2	54-9595 or 1(800)	367-7848.	If addit	ional spa	ce is ne	eded,	
please make a co	ppy of this form.							
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I CERTIFY THAT I HAV	E READ THIS FORM & \	ERIFY THAT ANY INFO	DRMATION PR	ROVIDED B	Y ME IS COI	RRECT.		
Date Signed:		Member's Signature						