OPERATING ENGINEERS LOCAL 37 HEALTH & WELFARE FUND

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

ENROLLMENT IN THE PLAN

Please complete the enclosed **Health Plan Enrollment Form** and return it to the Fund Office as soon as possible. **DO NOT DELAY:** this form must be completed when you are hired. You must list any dependents to be 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 a Spouse's plan), you must also complete and return a **Benefit Inquiry Questionnaire.**

Dependent Requirements

Dependent Regulients						
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.					
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. If you are adding a stepchild, copies of recorded Birth Certificate and legal documentation (e.g guardianship 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 click on Registration Documents. Then click on Registration — Document Upload Form and follow the instruction to submit your documents to a Secure Website.

OPERATING ENGINEERS LOCAL 37 STATIONARY GROUP 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 INFOR								n es		
Social Security Number	Last Name		First Name		Middle		Date of Birth		□ Female	
			011		D1 4-	7!-		□ Male		
Mailing Address			City		State	Zip	Home Phone:	()		
							Cell Phone:	()		
Martial Status (check one) ☐ Married ☐ Single	Date of Marriage	Date of Divorce	Spouse Date of Death	Curren	Employer:			,		
☐ Widowed ☐ Divorced	, ,	1 1		D	ate of Hire:					
	ECURITY N	UMBER FO	OR YOU AN			ENDENTS	MUST BE	PROVIDE	D	
Are you covered by any of	ther Health Pla	n as a partic	ipant or depe	ndent?		Are You Elig	ible for Medic	care?		
□ No □ Yes (if ye	es, you must com	plete the Benefit	t Inquiry Question	nnaire)		□ No □ Yes				
E-Mail Address:				Date of R	etirement	Medicare Entitlement Due to: □ Age □ Disability □ Renal Disease				
TYPE OF C	OVERAGI	E DESIRI	ED:			Please Return a Copy of Your Medicare				
□ SINGLE						Card Front & Back with this form.				
SPOUSE INFORMAT				MARINE SHEET					3 - 1 - 2 - 4 - 4 - 4 - 4 - 4 - 4 - 4 - 4 - 4	
Social Security Number	Last Name of Spo	ouse	First Name of Sp	ouse	Middle	Date o	of Birth	□ Male	□ Female	
								- Iviaio	- Tomale	
Mailing Address - City-State-Zip (if	f different from part	ticipant's)								
Name of Spouse's Employer (if an	y)		Address of Spou	se's Employer (if a	pplicable)					
Is the Spouse covered by	any other Hea	ilth Plan as a	participant o	r dependent?		Are You Elig	ible for Medic	care?		
1.00	es, you must com			-		□ No	□ Yes			
Spouse's E-Mail Address					etirement	Medicare En	titlement Due	e to:		
						□ Age	□ Disability	□ Renal D	isease	
(if different from	Home Phone:	()	_			Please Re	turn a Cop	y of Your	Medicare	
participant)	Cell Phone:	()				1	ard Front & Back with this form.			
DEPENDENT CHILD		ION						37325		
Social Security Number	Last Name of Chi		First Name of Ch	ild	Middle	Date	of Birth	□ Male	□ Female	
•								Wale	□ i emale	
Mailing Address - City-State-Zip (i	f different from par	ticipant's)								
Child is My:	Are You Eligi	ible for Medic	care?		Is the Child covered by any other Health Plan as a partic				participant or	
□ Natural □ Foster	□ No □ Yes				Dependent?					
□ Step □ Other	Medicare En	titlement Due	e to:		– No	□ Yes (if yes, you must complete			nplete the	
□ Adopted	□ Dis	ability	□ Renal Dise	ease	□ No	⊔ res		quiry Questionnaire)		
DEPENDENT CHILD	INFORMAT	ION								
Social Security Number	Last Name of Chi	ild	First Name of Ch	nild	Middle	Date	of Birth	□ Male	□ Female	
Mailing Address - City-State-Zip (i	f different from par	ticipant's)								
Child is My:	Are You Elig	ible for Medi	care?			-	ny other Heal	th Plan as a	participant or	
□ Natural □ Foster	□ No	□ Yes			Dependent?					
□ Step □ Other	Medicare En	titlement Due	e to:		□ No	U A 4 6		ou must complete the		
□ Adopted		sability	□ Renal Dise	ease			Benefit Inc	quiry Ques	stionnaire)	
DEPENDENT CHILD	WA CONTRACTOR OF THE PARTY OF T			Who place the	Ing. Lat		-6 Dist-			
Social Security Number	Last Name of Ch	ild	First Name of Ch	nild	Middle	Date	of Birth	□ Male	□ Female	
Mailing Address - City-State-Zip (I if different from par	rticipant's)	Lanca de la constante de la co							
Child is My	Are You Elig	ible for Medi	care?		Is the Child	covered by a	ny other Heal	th Plan as a	participant or	
Child is My: □ Natural □ Foster	□ No	□ Yes			Dependent?	_	_		Section 1997	
☐ Step ☐ Other	Medicare En		e to:			2.2	(if ves you		u must complete the	
□ Adopted		sability	□ Renal Dise	ease	□ No	□ Yes	Benefit Ind			
			ependent c	N.104056-197	ease contir	ue on the		, ,	-,	
I authorize the release to								equired to	establish the	
validity of any claim for b							,			
I CERTIFY THAT I HAVE READ THIS FORM & VERIFY THAT ANY INFORMATION PROVIDED BY ME IS CORRECT.										
ICERIIFY IH	ALIDAVEK	EAD I DIS F	OKIVI & VER	art imatal	AT INFORM	ATION FRO	AIDED DI M			
Date Signed:			_ Member'	s Signature:						

OPERATING ENGINEERS LOCAL 37 HEALTH & WELFARE FUND

HEALTH PLAN ENROLLMENT FORM

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List Additional Dependent Children Below:

DEPENDE	NT 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)							
J	,								
Child is My:		Are You Eligible for Medic	1	covered by ar	y other Heal	th Plan as a	participant or		
□ Natural	□ Foster	□ No □ Yes		Dependent?					
□ Step	□ Other	Medicare Entitlement Due	e to:	□ No	□ Yes	(if yes, you			
□ Adopted		□ Disability	□ Renal Disease		L 100	Benefit Inc	quiry Ques	tionnaire)	
DEPENDE	ENT CHILD	INFORMATION							
Social Security I	Number	Last Name of Child	First Name of Child	Middle	Date	of Birth	□ Male	□ Female	
Mailing Address	- City-State-Zin (if	different from participant's)							
maning Address	- Ony-Otate-Zip (ii	unicioni nom participanto,							
Child is My:		Are You Eligible for Medi	care?	Is the Child of	covered by a	ny other Heal	th Plan as a	participant or	
□ Natural	□ Foster	□ No □ Yes		Dependent?					
□ Step	□ Other	Medicare Entitlement Due	e to:	- No	(if yes, you must complete the				
□ Adopted	\$4.00 page services/spec	□ Disability	□ Renal Disease		□ No □ Yes			stionnaire)	
DEPENDE	ENT CHILD	INFORMATION							
Social Security	Number	Last Name of Child	First Name of Child	Middle	Date	of Birth	□ Male	□ Female	
Mailing Address	s - City-State-Zip (if	different from participant's)							
Child is My:		Are You Eligible for Medi	care?	Is the Child	covered by a	ny other Heal	th Plan as a	participant or	
□ Natural	□ Foster	□ No □ Yes		Dependent?	-			••••	
□ Step	□ Other	Medicare Entitlement Due	e to:			(if ves. vo	u must coi	mplete the	
□ Adopted	- Other	□ Disability	□ Renal Disease	□ No	□ Yes			stionnaire)	
	ENT CHILD	INFORMATION	- I toliai Biecaec						
Social Security		Last Name of Child	First Name of Child	Middle	Date	of Birth	☐ Male	□ Female	
-							Walc	- Tomale	
Mailing Address	s - City-State-Zip (if	f different from participant's)							
		Are You Eligible for Medi	looro?	le the Child	covered by a	ny other Heal	th Plan as a	a participant or	
Child is My:	- Ft	□ No □ Yes	carer	Dependent?		ily other rica	itii i iaii as t	partioipant of	
□ Natural	□ Foster	Medicare Entitlement Du	e to:			(if yee yo	u must co	mplete the	
☐ Step☐ Adopted	□ Other	□ Disability	□ Renal Disease	□ No	□ Yes			stionnaire)	
	ENT CHILD	INFORMATION	□ Iterial Disease			DONOR III	quiry Quo	otionnano)	
Social Security		Last Name of Child	First Name of Child	Middle	Date	of Birth	To Mala	□ Female	
,		ample Control Control State Control Control	S ESCHAL THE THE STATE OF THE SECURITY STATES				□ Male		
Mailing Address	s - City-State-Zip (i	f different from participant's)							
0.592.5.2 200		A V FR. 11.1	2	le the Child	agrand his	ny other Use	Ith Dian ac 4	a participant or	
Child is My:		Are You Eligible for Medi	icare?	Dependent?		пу оппет пеа	ıuı FIAII AS i	a participant of	
□ Natural	□ Foster	□ No □ Yes	o to:			(if you you	u must sa	mplata tha	
□ Step	□ Other	Medicare Entitlement Du		□ No	□ Yes			mplete the stionnaire)	
□ Adopted	CNT OUU D	□ Disability	□ Renal Disease			Denenii in	quiry Que	suominane)	
DEPENDI Social Security		INFORMATION Last Name of Child	First Name of Child	Middle	Date	of Birth	T		
Social Security	Manuel	Last Haine Of Gillu	I I SE MAINE OF CHILD	, and and	Jace		□ Male	□ Female	
Mailing Addres	s - City-State-Zip (i	f different from participant's)			•				
		_		<u>, , , , , , , , , , , , , , , , , , , </u>	Q. C	20 100			
Child is My:		Are You Eligible for Medicare?			Is the Child covered by any other Health Plan as a participant of				
□ Natural	□ Foster	□ No □ Yes		Dependent?					
□ Step	□ Other	Medicare Entitlement Du	care Entitlement Due to:				s, you must complete the		
□ Adopted		□ Disability	□ Renal Disease	1 1,10		Benefit In	quiry Que	stionnaire)	
I CERTIFY	THAT I HAV	E READ THIS FORM &	VERIFY THAT ANY II	NFORMATION P	ROVIDED E	BY ME IS CO	RRECT.		
Date	Signed:		Member's Signat	ture:					
Date	-19110di								