OPERATING ENGINEERS LOCAL 37 HEALTH & WELFARE FUND

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

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 **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 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 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:

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?
☐ 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

Please Return a Copy of Your Medicare Card Front & Back with this form.

TYPE OF COVERAGE DESIRED:

☐ SINGLE ☐ DUAL ☐ FAMILY

SPOUSE INFORMATION

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

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)

Child is My: ☐ 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)

Child is My: ☐ 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)

Child is My: ☐ 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 more dependent children, please continue on the next page

I authorize the release to and use by O.E. LOCAL 37 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: OEBF Local 37 - Attn: Registration Dept - 3615 North Point Blvd Ste C - Baltimore MD 21222

OPERATING ENGINEERS LOCAL 37
HEALTH & WELFARE FUND

HEALTH PLAN ENROLLMENT FORM

List Additional Dependent Children Below:

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)

Child is My: ☐ 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)

Child is My: ☐ 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)

Child is My: ☐ 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)

Child is My: ☐ 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)

Child is My: ☐ 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)

Child is My: ☐ 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 CERTIFY THAT I HAVE READ THIS FORM & VERIFY THAT ANY INFORMATION PROVIDED BY ME IS CORRECT.

Date Signed: ________________ **Member's Signature:** ______________________________

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