# OPERATING ENGINEERS TRUST FUNDS

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

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## Group Insurance Questionnaire

### Member Information

| Social Security Number/ OE ID | Last Name | First Name | Middle Name |
|---|---|---|---|
| | | | |

| Mailing Address | City | State | Zip Code |
|---|---|---|---|
| | | | |
| **Physical Address (If different from mailing address)** | **City** | **State** | **Zip Code** |
| | | | |

| Home Phone Number | Mobile Phone Number | Email Address |
|---|---|---|
| ☐ Preferred | ☐ Preferred | |

Are you covered by any other health plan as a participant or dependent?
☐ No ☐ Yes (If yes, please answer the following questions)

**Social Security Number for you and all your dependents must be provided.**

| Name of Employer who provides this coverage | Employer's Address | Employer's Phone |
|---|---|---|
| | | |

Are you also covered by Medicare? (Please attach a copy of your Medicare card when you return this form.)
☐ No ☐ Yes (If yes, please provide the effective date of your Medicare coverage _____/_____/_____

### Spouse Information

| Social Security Number | Last Name | First Name | Middle Name |
|---|---|---|---|
| | | | |

| Mailing Address | City | State | Zip Code |
|---|---|---|---|
| | | | |
| **Physical Address (If different from mailing address)** | **City** | **State** | **Zip Code** |
| | | | |

| Home Phone Number | Mobile Phone Number | Email Address |
|---|---|---|
| ☐ Preferred | ☐ Preferred | |

Are you covered by any other health plan as a participant or dependent?
☐ No ☐ Yes (If yes, please answer the following questions)

| Name of Employer who provides this coverage | Employer's Address | Employer's Phone |
|---|---|---|
| | | |

Are you also covered by Medicare? (Please attach a copy of your Medicare card when you return this form.)
☐ No ☐ Yes (If yes, please provide the effective date of your Medicare coverage _____/_____/_____

### Other Medical Insurance - Important: Please attach a copy of the other insurance card

| Name of Medical Insurance Carrier | Medical Insurance Carrier's Address | Insurance Carrier's Phone Number |
|---|---|---|
| | | |

| Name of Policy Holder | Policy Number | Effective Date | Type of Policy | Type of Medical Plan |
|---|---|---|---|---|
| | | | ☐ Group ☐ Private ☐ Retiree Plan | ☐ HMO ☐ PPO ☐ EPO ☐ POS |

### Other Dental Insurance - Important: Please attach a copy of the other insurance card

| Name of Dental Insurance Carrier | Dental Insurance Carrier's Address | Insurance Carrier's Phone Number |
|---|---|---|
| | | |

| Name of Policy Holder | Policy Number | Effective Date | Type of Policy | Type of Dental Plan |
|---|---|---|---|---|
| | | | ☐ Group ☐ Private ☐ Retiree Plan | ☐ DHMO ☐ DPPO ☐ EPO ☐ POS |

I certify under penalty of perjury that to the best of my knowledge all information provided on this document is true, correct and complete.

| **Member's Signature (Required)** | Date |
|---|---|
| X | _____/_____/_____ |

**Please complete reverse side to list dependents covered by these plans**

## Other Medical Policy:

| List all dependents that are covered by the other medical policy | | |
|---|---|---|
| Full Name | Social Security Number | If a step-child, who is custodial parent? |
| Full Name | Social Security Number | If a step-child, who is custodial parent? |
| Full Name | Social Security Number | If a step-child, who is custodial parent? |
| Full Name | Social Security Number | If a step-child, who is custodial parent? |
| Full Name | Social Security Number | If a step-child, who is custodial parent? |
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| Full Name | Social Security Number | If a step-child, who is custodial parent? |
| Full Name | Social Security Number | If a step-child, who is custodial parent? |
| Full Name | Social Security Number | If a step-child, who is custodial parent? |

## Other Dental Policy:

| List all dependents that are covered by the other dental policy. If the dependents are same as above, check here ☐ | | |
|---|---|---|
| Full Name | Social Security Number | If a step-child, who is custodial parent? |
| Full Name | Social Security Number | If a step-child, who is custodial parent? |
| Full Name | Social Security Number | If a step-child, who is custodial parent? |
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