OPERATING ENGINEERS TRUST FUNDS

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

100 CORSON STREET, SUITE 100 • PASADENA, CALIFORNIA 91103 • (866) 400-5200
P.O. BOX 7063, PASADENA, CALIFORNIA 91109
TTY: (626) 356-3582 WEBSITE: www.oefi.org

PLAN ENROLLMENT

New federal laws require the Fund to collect enrollment information on all Plan participants. Please complete the enclosed **Health Plan Enrollment Form** and return it to the Fund Office as soon as possible. You must list any dependents 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 Medicare or a spouse's), you must also complete and return a **Group Insurance Questionnaire.**

This information will assist the Health & Welfare Fund in complying with these federal laws.

Note: 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) **Copies of Social Security cards for you and your dependents are requested for accuracy.**

Dependent Requirements

If You Want To:	**Documentation Required by the Plan**
Add a new dependent spouse	Certified marriage certificate (required). Copy of their Social Security Card.
Remove a divorced spouse	Copy of the recorded final divorce decree (required).
Add your dependent child under age 19	Certified birth certificate (required). Copy of their Social Security Card(s).
Add a foster child, adopted child or a child for whom you are the legal guardian	Certified birth certificate and legal documentation e.g. adoption or guardianship papers issued by the court (required). Copy of their Social Security Card(s).
Add your dependent child age 19 to 26	Certified birth certificate (required). Copy of their Social Security Card(s). A Young Adult's spouse and children are **not eligible** to enroll in this Plan.

All of these forms are available to download and print from the Fund's website at:
http://www.oefi.org

OPERATING ENGINEERS TRUST FUNDS

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

100 CORSON STREET, SUITE 100 • PASADENA, CALIFORNIA 91103 • (866) 400-5200
P.O. BOX 7063, PASADENA, CALIFORNIA 91109
TTY: (626) 356-3582 WEBSITE: www.oefi.org

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 (Local 12 Member) Information

Social Security Number/OE ID	Last Name	First Name	Middle

Date of Birth	☐ Male ☐ Female	Home Phone # (_____)_____	Mobile Phone # (_____)_____

Mailing Address	City	State	ZIP Code

Physical Address (If different from mailing address)	City	State	ZIP Code

Marital Status (Check One): ☐ Married ☐ Single ☐ Widowed ☐ Divorced	Date of Marriage	Date of Divorce	Spouse Date of Death	**SOCIAL SECURITY NUMBER FOR YOU AND ALL OF YOUR DEPENDENTS MUST BE PROVIDED.**

E-mail address:	Medicare eligible? ☐ No ☐ Yes (see below)	If yes, please return a copy of your **Medicare card** with this form.

Are you covered by any other health plan as a participant or dependent? ☐ No ☐ Yes (if yes, you must complete the **Group Insurance Questionnaire**)	Medicare-entitled due to: ☐ Age ☐ Disability ☐ Renal Disease

Spouse Information

Social Security Number	Last Name of Spouse	First Name of Spouse	Middle Name of Spouse

Mailing Address (with City, State & ZIP) – if different from participant's	☐ Male ☐ Female	Date of Birth

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

Are you covered by any other health plan as a participant or dependent? ☐ No ☐ Yes (if yes, you must complete the **Group Insurance Questionnaire**)	Medicare eligible? ☐ No ☐ Yes (see below)	If yes, please return a copy of your **Medicare card** with this form.
	Medicare-entitled due to: ☐ Age ☐ Disability ☐ Renal Disease	

Dependent Child Information - Use reverse side to add additional dependents

Social Security Number	Last Name of Child	First Name of Child	Middle Name of Child

Mailing Address (with City, State & ZIP) – if different from participant's	☐ Male ☐ Female	Date of Birth

Child is my: ☐ Natural ☐ Foster ☐ Stepchild ☐ Adopted ☐ Other: _____	Is this child covered by any other health plan as a participant or dependent? ☐ No ☐ Yes (if yes, you must complete the **Group Insurance Questionnaire**)	Medicare eligible? ☐ No ☐ Yes (see below)	If yes, please return a copy of your **Medicare card** with this form.
		Medicare-entitled due to: ☐ Disability ☐ Renal Disease	

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

Participant's Signature (Required)	
X	**Date**

Dependent Child Information (continued)

Social Security Number	Last Name of Child	First Name of Child	Middle Name of Child
Mailing Address (with City, State & ZIP) – if different from participant's		☐ Male ☐ Female	Date of Birth

Child is my: ☐ Natural ☐ Foster ☐ Stepchild ☐ Adopted ☐ Other: _______________

Is this child covered by any other health plan as a participant or dependent? ☐ No ☐ Yes (if yes, you must complete the **Group Insurance Questionnaire**)

Medicare eligible? ☐ No ☐ Yes (see below)

If yes, please return a copy of your **Medicare card** with this form.

Medicare-entitled due to: ☐ Disability ☐ Renal Disease

Social Security Number	Last Name of Child	First Name of Child	Middle Name of Child
Mailing Address (with City, State & ZIP) – if different from participant's		☐ Male ☐ Female	Date of Birth

Child is my: ☐ Natural ☐ Foster ☐ Stepchild ☐ Adopted ☐ Other: _______________

Is this child covered by any other health plan as a participant or dependent? ☐ No ☐ Yes (if yes, you must complete the **Group Insurance Questionnaire**)

Medicare eligible? ☐ No ☐ Yes (see below)

If yes, please return a copy of your **Medicare card** with this form.

Medicare-entitled due to: ☐ Disability ☐ Renal Disease

Social Security Number	Last Name of Child	First Name of Child	Middle Name of Child
Mailing Address (with City, State & ZIP) – if different from participant's		☐ Male ☐ Female	Date of Birth

Child is my: ☐ Natural ☐ Foster ☐ Stepchild ☐ Adopted ☐ Other: _______________

Is this child covered by any other health plan as a participant or dependent? ☐ No ☐ Yes (if yes, you must complete the **Group Insurance Questionnaire**)

Medicare eligible? ☐ No ☐ Yes (see below)

If yes, please return a copy of your **Medicare card** with this form.

Medicare-entitled due to: ☐ Disability ☐ Renal Disease

Social Security Number	Last Name of Child	First Name of Child	Middle Name of Child
Mailing Address (with City, State & ZIP) – if different from participant's		☐ Male ☐ Female	Date of Birth

Child is my: ☐ Natural ☐ Foster ☐ Stepchild ☐ Adopted ☐ Other: _______________

Is this child covered by any other health plan as a participant or dependent? ☐ No ☐ Yes (if yes, you must complete the **Group Insurance Questionnaire**)

Medicare eligible? ☐ No ☐ Yes (see below)

If yes, please return a copy of your **Medicare card** with this form.

Medicare-entitled due to: ☐ Disability ☐ Renal Disease

Social Security Number	Last Name of Child	First Name of Child	Middle Name of Child
Mailing Address (with City, State & ZIP) – if different from participant's		☐ Male ☐ Female	Date of Birth

Child is my: ☐ Natural ☐ Foster ☐ Stepchild ☐ Adopted ☐ Other: _______________

Is this child covered by any other health plan as a participant or dependent? ☐ No ☐ Yes (if yes, you must complete the **Group Insurance Questionnaire**)

Medicare eligible? ☐ No ☐ Yes (see below)

If yes, please return a copy of your **Medicare card** with this form.

Medicare-entitled due to: ☐ Disability ☐ Renal Disease

Social Security Number	Last Name of Child	First Name of Child	Middle Name of Child
Mailing Address (with City, State & ZIP) – if different from participant's		☐ Male ☐ Female	Date of Birth

Child is my: ☐ Natural ☐ Foster ☐ Stepchild ☐ Adopted ☐ Other: _______________

Is this child covered by any other health plan as a participant or dependent? ☐ No ☐ Yes (if yes, you must complete the **Group Insurance Questionnaire**)

Medicare eligible? ☐ No ☐ Yes (see below)

If yes, please return a copy of your **Medicare card** with this form.

Medicare-entitled due to: ☐ Disability ☐ Renal Disease

Please return form to: Operating Engineers Health & Welfare Fund, PO Box 7067, Pasadena, CA 91109