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 <u>all</u> 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

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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 Mi										
Social Security Number/OE ID	Last Name	le			First Name			Middle		
Date of Birth		Home Pho		ne #		Mobile	Mobile Phone #			
		Male								
Female		()		()				
Mailing Address			City			State ZIP Code				
Physical Address (If different from mailing address)				City St			State	ZIP Code		
Marital Status (Check One):		Date of Marriage	Date of Divorce		Spource	e Date of Death				
□ Married □ Single		Date of Marilage	Date of Divorce				RITY NUMBER F	TY NUMBER FOR YOU AND ALL OF		
						YOUR DEPEN		DENTS <u>MUST</u> BE PROVIDED.		
Widowed Divorced E-mail address:				Marali an un	dicare eligible?					
E-mail address.				-		If yes,		es, please return a copy of your		
					□ Yes (see	below)	Medicare	card with this fo	rm.	
Are you covered by any other health plan as a participant or dependent? Med				Medicare-	entitled due	to:				
□ No □ Yes (if yes, you must complete the Group Insurance Questionnaire) □ Age				🗆 Age	🗆 Disabilit	y 🛛 Renal Disease				
Spouse Information										
Social Security Number	Last Name	of Spouse			First Name	e of Spouse		Middle Name	e of Spouse	
Mailing Address (with City, State & 7ID)	_ if different f	from participant's							Date of Birth	
Mailing Address (with City, State & ZIP) – if different from participant's						Male	Date of birth			
								Female		
Name of Spouse's Employer (if any):			Addre	ss of Spouse's	s Employer (if applicable)					
						please return a copy of your				
Are you covered by any other hea							card with this fo	rm.		
□ No □ Yes (if yes, you must complete the Group Insurance Questionnaire)			Medicare-entitled due to:							
				□ Age		y 🗌 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	Middle Name of Child	
Mailing Address (with City, State & ZIP)	– if different f	from participant's							Date of Birth	
								Male		
								Female		
Child is my:	Child is my:							yes, please return a copy of your		
Natural Foster	□ Natural □ Foster			participant	nt or 🛛 No 🖓 Yes (see below) 🗖			Medicare card	with this form.	
□ Stepchild □ Adopted		dependent? \Box No \Box Yes (if yes, you must complete the			Medicare-entitled due to:					
	0	Group Insurance Questionnaire)			Disability Renal Disease					
□ Other:										
I certify under penalty of per		o the best of my knowledge	e all informatio	n provide	d on this d	document is true, corre	ct and com	iplete.		
Participant's Signature (Requ	ired)									
							Da	te		
x										
								DE 4 00		

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:	Is this child covered by any other health plan as a participant or		Medicare eligible?	If yes, please return a copy of your Medicare card with this form.					
Stepchild Adopted Other:	dependent? Ves (if yes, you must complete the Group Insurance Questionnaire)	Medicare-entitled due to:							
Social Security Number	Last Name of Child	st Name of Child First Name of Child							
Mailing Address (with City, State & ZIF				Male Female	Date of Birth				
Child is my:	Is this child covered by any other health plan as a participant or	Medicare eligible?			If yes, please return a copy of your Medicare card with this form.				
Stepchild Adopted Other:	dependent? Ves (if yes, you must complete the Group Insurance Questionnaire)	Medicare-entitled due to: Disability Renal Disease							
Social Security Number	Last Name of Child	First Na	me of Child		Middle Name	of Child			
-									
Mailing Address (with City, State & ZIF) – if different from participant's				MaleFemale	Date of Birth			
Child is my:			Medicare eligible?	'		a copy of your			
Natural Soster	Is this child covered by any other health plan as a participant or		□ No □ Yes (see below) Medicare card with this form.						
□ Stepchild □ Adopted	dependent? \Box No \Box Yes (if yes, you must complete the		Medicare-entitled due to:						
□ Other:	Group Insurance Questionnaire)		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	Date of Birth			
					Female				
Child is my:					es, please return a copy of your dicare card with this form.				
Natural Foster	Is this child covered by any other health plan as a participant or	□ No □ Yes (see below)							
□ Stepchild □ Adopted	dependent? No Yes (if yes, you must complete the Group Insurance Questionnaire)		Medicare-entitled due to:						
□ Other:			Disability Renal Disease						
Social Security Number	al Security Number Last Name of Child		First Name of Child			Middle Name of Child			
Mailing Address (with City, State & ZIF					□ Male	Date of Birth			
) – if different from participant's				Female				
Child is my:	– if different from participant's		Medicare eligible?	If yes	Female	a copy of your			
) - if different from participant's Is this child covered by any other health plan as a participant or		Medicare eligible?		Female				
□ Natural □ Foster			□ No □ Yes (see below)		□ Female 5, please return				
 Natural Foster Stepchild Adopted 	Is this child covered by any other health plan as a participant or		-		□ Female 5, please return				
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)		No Yes (see below) Medicare-entitled due to: Disability Renal Disease		□ Female 5, please return icare card with	this form.			
 Natural Foster Stepchild Adopted 	Is this child covered by any other health plan as a participant or dependent? \Box No \Box Yes (if yes, you must complete the	First Na	No Yes (see below) Medicare-entitled due to:		□ Female 5, please return	this form.			
Natural Foster Stepchild Adopted Other:	Is this child covered by any other health plan as a participant or dependent? \Box No \Box Yes (if yes, you must complete the Group Insurance Questionnaire) Last Name of Child	First Na	No Yes (see below) Medicare-entitled due to: Disability Renal Disease		□ Female 5, please return icare card with	this form.			
Natural Foster Stepchild Adopted Other: Social Security Number Mailing Address (with City, State & ZIF	Is this child covered by any other health plan as a participant or dependent? \Box No \Box Yes (if yes, you must complete the Group Insurance Questionnaire) Last Name of Child	First Na	No Yes (see below) Medicare-entitled due to: Disability Renal Disease	Medi	Female s, please return icare card with Middle Name G Male Female	this form.			
Natural Foster Stepchild Adopted Other: Social Security Number Mailing Address (with City, State & ZIF Child is my:	Is this child covered by any other health plan as a participant or dependent? \Box No \Box Yes (if yes, you must complete the Group Insurance Questionnaire) Last Name of Child	First Na	 No ☐ Yes (see below) Medicare-entitled due to: ☐ Disability ☐ Renal Disease me of Child 	Medi	Female s, please return icare card with Middle Name G Male Female	this form.			
Natural Foster Stepchild Adopted Other: Social Security Number Mailing Address (with City, State & ZIF Child is my: Natural Foster	Is this child covered by any other health plan as a participant or dependent? Yes (if yes, you must complete the Group Insurance Questionnaire) Last Name of Child	First Na	No Yes (see below) Medicare-entitled due to:	Medi	Female Female Middle Name Middle Name Male Female S, please return	this form.			
Natural Foster Stepchild Adopted Other: Social Security Number Mailing Address (with City, State & ZIF Child is my:	Is this child covered by any other health plan as a participant or dependent? Yes (if yes, you must complete the Group Insurance Questionnaire) Last Name of Child)- if different from participant's Is this child covered by any other health plan as a participant or	First Na	No Yes (see below) Medicare-entitled due to: Disability Renal Disease me of Child Medicare eligible? No Yes (see below)	Medi	Female Female Middle Name Middle Name Male Female S, please return	this form.			

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