Operating Engineers Local 139 Health Benefit Fund

P O Box 160, Pewaukee, WI 53072 (Toll Free) 800-242-7018 (Fax) 262-549-3549

Participant Information (IUOE 139 Member)

Print Participant's Last Name	Suffix	First Name	Social Security No. or OEF No.

Street Address	City	State	Zip

Email Address:	Birth Date (MM/DD/YY)

Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

Primary Phone Number:

Spouse Information

Print Spouse's Last Name	Spouse's First Name	Spouse's Telephone Number

Is spouse Employed? ☐ Yes ☐ No ☐ Self Employed

If you answered "No" or "Self Employed", sign and date the form below.

If the spouse is employed but is not eligible for other coverage, the spouse must provide a letter from that employer (on company letterhead) stating the reason that no coverage is available. If coverage is available but is not taken, the spouse will <u>not</u> be covered under this Plan for medical or prescription drugs.

If the spouse previously had insurance from the spouse's employer and are either no longer employed or no longer eligible for the employer's coverage, please provide written documentation of the termination date of that other coverage. **If no documentation is provided, eligibility with this Fund will be reinstated as of the date the signed form is received by the Fund Office.**

Spouse's Employer Name and Address:	Spouse's Employer Telephone Number:

Does the spouse's employer offer health coverage/insurance to employees? ☐ Yes ☐ No

Effective date of existing coverage or date when the spouse will be eligible to enroll for health coverage/insurance under the employer's plan?

Does your spouse have other health coverage/insurance (besides Operating Engineers)? If yes, provide the following: ☐ Yes ☐ No

Name of other health coverage/insurance company:

Is the other coverage a Health Savings Account (HSA)? ☐ Yes ☐ No

If yes, there will be no secondary medical or prescription drug coverage from this Fund. In order to ensure that contributions to a health savings account are possible, the IRS does not allow you to have a High Deductible Health Plan and an HSA with our type of plan that is NOT a High Deductible Health Plan. Call the Fund Office for more information.

Type of other Coverage: ☐ Family ☐ Single

Check all that apply: ☐ Medical/Rx ☐ Dental ☐ Vision

Spouse Authorization

<u>All spouses must sign this section</u>. I certify that all of the information contained in this form is accurate and complete to the best of my knowledge. For working spouses, I authorize my employer, if any, to release information regarding my employer's health coverage/insurance plan and my eligibility for coverage under that plan to the Operating Engineers Local 139 Health Benefit Fund, (the "Health Fund"). I understand that this authorization shall remain in effect as long as I am eligible for benefits under the Health Fund. I understand that the purpose and scope of this authorization is to allow the Health Fund to verify with my employer, if any, whether I am eligible to collect or obtain coverage under my employer's health plan. I understand it is my responsibility to notify the Health Fund of any change in employment, coverage or the above-described information. I further understand and acknowledge that, if I fail to disclose eligibility for, or enrollment in, my employer's health coverage/insurance plan, that coverage under the Health Fund will be retroactively terminated as of the date of eligibility or enrollment in my employer's health coverage/insurance plan, and I will be obligated to repay all claims paid by the Health Fund during the time I was eligible for, or enrolled in, my employer's health coverage/insurance plan to the extent allowed by law.

Spouse's Signature: **Date:**

Participant Authorization

I hereby certify that all of the information contained in this form is accurate and complete to the best of my knowledge. I also understand that the Health Fund will have the right to cancel my spouse's coverage retroactively in the case of fraud or an intentional misrepresentation of a material fact and to seek reimbursement for any benefits wrongfully paid.

Participant's Signature: **Date:**