Operating Engineers Local 139 Health Benefit Fund

P O Box 160, Pewaukee, WI 53072-0160, 262-549-9190 or toll free 800-242-7018

Participant Information

Print Participant's Last Name	First Name	Middle Initial	Sex: ☐ Male ☐ Female
Street Address	City	State	Zip
Social Security No. or OEF No.		Birth Date (MM/DD/YY)	
Home Phone Number ( )		Cell Phone Number ( )	
Marital Status and Date: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated		Email Address	

Spouse Information

Print Spouse's Last Name	Spouse's First Name	Middle Initial	Sex ☐ Male ☐ Female
Spouse's Social Security No.	Date of Marriage: (MM/DD/YY)	Spouse's Birth Date (MM/DD/YY)	
Is spouse Employed: ☐ Yes ☐ No ☐ Self Employed	If you answered "No" or "Self Employed", sign and date the form below.	**If your spouse is employed but is not eligible for other coverage, you 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, your spouse will <u>not</u> be covered under this Plan.**	
Spouse's Employer Name:		Spouse's Employer Telephone Number:	
Spouse's Employer Address:	City	State	Zip
Does your spouse's employer offer health coverage/insurance to employees? ☐ Yes ☐ No	When is your spouse eligible to enroll for health coverage/insurance under the employer's Plan?		
Does your spouse have other health coverage/insurance? If yes, provide the following: ☐ Yes ☐ No ☐ Medicare ☐ Badgercare	Name of other health coverage/insurance company:		
Is the other coverage a Health Savings Account (HSA)? Yes____ No____. If yes, there will be no additional coverage from this Fund. The IRS does not allow this Fund to coordinate benefits with an HSA plan.		Telephone number of health coverage/ insurance company:	
Effective Date of coverage:	Type of Coverage: ☐ Family ☐ Single	Check all that apply: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription	

Spouse Authorization

<u>All spouses must sign this section</u>. For working spouses, I hereby authorize my employer, _____, 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. I understand that this authorization shall remain in effect as long as I am eligible for benefits under the Operating Engineers Local 139 Health Benefit Fund. I understand that the purpose and scope of this authorization is to allow the Operating Engineers Local 139 Health Benefit Fund to verify with my employer whether I am eligible to collect or obtain coverage under my employer's health plan. **<u>For all spouses</u>**: I hereby certify that all of the information contained in this form is accurate and complete to the best of my knowledge.

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 Plan 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:**