Operating Engineers Local 139 Health Benefit Fund

N27 W23233 Roundy Drive, P O Box 160, Pewaukee, WI 53072-0160, 262-549-9190 or toll free 800-242-7018

Enrollment Form

Please complete both sides. Coverage may be delayed and the form will be returned for incomplete information or missing signatures.

Reason for Form Check one:	New Participant	Add Spouse	Add Child	Divorce	Update Spouse Coverage	Update Beneficiary	Other	Date:
	☐	☐	☐	☐	☐	☐	☐	

Participant Information (IUOE member)

Print Participant's Last Name	First Name	Middle Initial	Sex: ☐ Male ☐ Female

Address Street Number	City	State	Zip

Social Security Number or OEF Number	Birth Date (MM/DD/YY)

Home Phone Number	Cell Phone Number
( )	( )

Marital Status and Date: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

Email Address

Dependent Information

You must complete the following information for each of your dependents. Additional dependents may be attached on a second sheet.

Relationship	Print Dependent's Name (Last, First, MI)	Sex	Birthdate	Social Security No.
Spouse		☐ Male ☐ Female	/ /	- -
		☐ Male ☐ Female	/ /	- -
		☐ Male ☐ Female	/ /	- -
		☐ Male ☐ Female	/ /	- -
		☐ Male ☐ Female	/ /	- -

Dependent Documentation/Proof

You must also enclose a Certified State or County <u>duplicate</u> of the birth certificate to cover your child and/or a marriage certificate to cover your spouse. If you send originals, they will be returned to you. A certified duplicate is a copy acquired from the state or county in which the birth occurred. Hospital and church records are <u>not</u> acceptable. All information must be completed and provided or your dependents will not be enrolled under your group health coverage. **If your dependent was previously covered under the Plan, you are not required to provide documentation again.**

Unless your adult dependents contact the Fund and provide an alternate address, their EOB (Explanation of Benefits) and any PHI (Protected Health Information) will be sent to your address.

Medicare Coordination of Benefits Information

Are you, your spouse, or dependent child(ren) eligible for Medicare? Yes ☐ No ☐

If yes, name of person eligible for Medicare_____

Medicare ID Number:_____

If Yes, submit a copy of the Medicare card

Dependent Children Coordination of Benefits Information - (Spouse use other side of form)

Do your dependent children have coverage under any other group plan providing health benefits: Yes ☐ No ☐

If yes, name of dependent:_____ Name of Insurance Company:_____

Effective Date of coverage:	Type of Coverage: ☐ Family ☐ Single	Check all that apply: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription

Complete other side ➡

Spouse Information

Print Spouse's Last Name	Spouse's First Name	Middle Initial	Sex ☐ Male ☐ Female

Spouse's Social Security Number	Date of Marriage: (MM/DD/YY)	Spouse's Birth Date (MM/DD/YY)

Is spouse Employed: ☐ Yes ☐ No ☐ Self-Employed	If you answered "No", 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 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. I understand it is my responsibility to notify the Fund of any changes. **<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:** _____

Death Benefit Beneficiary Designation

I hereby authorize the Operating Engineers Local 139 Health Benefit Fund to make benefit payment of any Death Benefit and/or Accidental Death Benefit to which I may be entitled to the following person who I designate as my beneficiary:

Beneficiary Name:_____ Relationship to you:_____

Beneficiary Address:_____

I understand and agree that this beneficiary designation will remain in effect unless and until a new Enrollment Form as provided by the Fund is dated and signed by me and received at the Fund Office prior to the date of my death. Further, I understand that if I choose to leave this Beneficiary Designation blank (incomplete) or if my beneficiary dies before me, my death benefit will be paid in the following order to my living: spouse, children, parents, brothers and sisters or to my estate. This designation applies only to the Operating Engineers Local 139 Health Benefit Fund and is not valued for any death benefits for which I may be eligible from the Central Pension Fund nor any I.U.O.E. death benefit.

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:** _____