



# IUOE LOCAL 399 HEALTH AND WELFARE PLAN ENROLLMENT FORM

## MEMBER INFORMATION (Please Print)

Name: \_\_\_\_\_  
Last First Middle

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Gender: ( ) M ( ) F Marital Status: ( ) Single ( ) Married Marriage Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Contact Information

Home: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_

Home Email: \_\_\_\_\_ Date Employed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer Name: \_\_\_\_\_ Job Site: \_\_\_\_\_

### OFFICE USE ONLY

Coverage Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ ID# 93990 \_\_\_\_\_

Prior Coverage \_\_\_\_ Y \_\_\_\_ N Notes: \_\_\_\_\_

## DEPENDENT ENROLLMENT INFORMATION (Please Print)

Spouse Name (Marriage Certificate Required) \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Sec. No. \_\_\_\_\_

Does Your Spouse Have Group Insurance Through An Employer? ( ) Yes ( ) No  
*(If yes, please complete reverse side)*

Child Name(s): (Birth Certificate Required) \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: ( ) M ( ) F  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Office Use Only

## BENEFICIARY INFORMATION (Please Print)

### HEALTH & WELFARE DEATH BENEFIT

NAME	BIRTHDATE	RELATIONSHIP	ADDRESS / PHONE # <small>(If different from above)</small>

### LOCAL 399 DEATH BENEFIT

I designate the same beneficiary for **BOTH** my Health & Welfare death benefit and my Local 399 member death benefit:  YES  NO  
If NO, please designate beneficiary below for my LOCAL 399 DEATH BENEFIT only:

NAME	BIRTHDATE	RELATIONSHIP	ADDRESS / PHONE #

I certify that all information provided to the Fund Office on this form is correct and that the beneficiary listed above was designated by me on this date.

\_\_\_\_\_  
Signature of Member

\_\_\_\_\_  
Date

### Required Documents for Dependent Enrollment

- An original Marriage Certificate will be required by the Fund for purposes of covering your spouse.
- An original Birth Certificate or legal adoption document will be required by the Fund for purposes of enrolling your child or children.
- If you are divorced and want to enroll your child or children on the Plan, a copy of your Divorce Decree or Qualified Medical Child Support Order will also be required, for purposes of determining whether you and/or your ex-spouse is responsible for providing medical coverage. (Only the relevant pages of the court document are required).

All original documents will be returned to you once the H&W Fund Office records them (unless you state otherwise). You may prefer to bring the original documents to the H&W Fund Office Monday through Friday between the hours of 8:00am and 4:30pm.

PLEASE NOTE: Step-children are not eligible dependents under the Plan.

I HEREBY AFFIRM UNDER PENALTIES OF PERJURY THAT I HAVE VERIFIED WITH MY CHILD(REN) NAMED ON THIS FORM THAT HE/SHE IS NOT ELIGIBLE TO ENROLL IN, NOR IS HE/SHE COVERED BY EMPLOYER SPONSORED HEALTH COVERAGE THROUGH HIS/HER OWN EMPLOYER OR HIS/HER SPOUSE'S EMPLOYER. I ALSO CERTIFY THAT I WILL NOTIFY THE FUND OFFICE IMMEDIATELY IF MY CHILD(REN) BECOMES ELIGIBLE FOR OR COVERED BY EMPLOYER SPONSORED HEALTH COVERAGE THROUGH HIS/HER EMPLOYER OR HIS/HER SPOUSE'S EMPLOYER.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### Coordination of Benefits Information

If you indicated on the reverse side that your spouse has other individual or family coverage through an employer group plan, please provide details below:

Spouse Employer: \_\_\_\_\_ Insurance Carrier: \_\_\_\_\_

Family Members Covered: ( ) All ( ) Spouse Only ( ) Other \_\_\_\_\_

Type of Coverage: ( ) Medical ( ) Dental ( ) Other \_\_\_\_\_

Additional Notes: \_\_\_\_\_

Do you, the member have other coverage through a current or past employer? ( ) Yes ( ) No

If Yes, who \_\_\_\_\_

Are you or any member(s) of your family eligible for Medicare due to age or disability? ( ) Yes ( ) No

### Decline Dependent Enrollment

If you are declining enrollment for your dependents (including your spouse) because coverage is available under the employer coverage stated above, you will be able to enroll your dependents in this plan *only* if your dependents lose eligibility for that other coverage. **You must, however, request enrollment within 30 days after your dependents' other coverage ends, with proof of termination of coverage from the employer.**

Name	Relationship	Date of Birth

\_\_\_\_\_  
Member Signature

\_\_\_\_\_  
Date

### Effective Date of Coverage

Your coverage will begin on the first day of the month following your date of hire or the date your employer is contractually obligated to begin your health and welfare contribution.

You will be mailed medical, prescription and dental identification cards upon receipt of this form and all required documents. You will also be provided with a Summary Plan Description and other related information about the plan.

### Termination of Coverage

Coverage for you and your dependents will end on the last day of the month in which your employment and/or coverage ends. COBRA continuation coverage information will be sent to you by the H&W Fund Office.

It is important that you notify the H&W Fund Office within 30 days of the date your spouse, child or children are no longer an eligible dependent so that important COBRA continuation coverage information can be sent (See Summary Plan Description for more information). Please complete a Dependent Change Form, which can be downloaded at [www.iuoe399.org](http://www.iuoe399.org) (Health and Welfare page) or requested from the Fund Office: IUOE Local 399 H&W Fund • 2260 S. Grove Street • Chicago, IL 60616 • Office (312) 372-9870 • Fax (312) 842-0291