



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
Zip

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

Contact Information

Home: () _____ Cell: () _____ Work: () _____

Email: _____ Job Site: _____

Employer Name: _____ Date Employed: ____/____/____

DEPENDENT ENROLLMENT INFORMATION (Please Print)

Spouse Name (Marriage Certificate Required)	Date of Birth	Social Sec. No.	<small>Office Use Only</small>
_____	____/____/____	_____	<input type="checkbox"/>

Does Your Spouse Have Group Insurance Through An Employer? () Yes () No

Child Name(s): (Birth Certificate Required)	Date of Birth	Gender:	
_____	____/____/____	() M () F	<input type="checkbox"/>
_____	____/____/____	() M () F	<input type="checkbox"/>
_____	____/____/____	() M () F	<input type="checkbox"/>
_____	____/____/____	() M () F	<input type="checkbox"/>
_____	____/____/____	() M () F	<input type="checkbox"/>
_____	____/____/____	() M () F	<input type="checkbox"/>

The Plan provisions allow enrollment of your children who are verified as your natural children by presentation of original birth certificate and who are dependent upon you for support. See Summary Plan Description for further details. Eligible children are covered to age 19 unless documentation of full-time student status is provided. Eligible full-time students are covered to age 23.

BENEFICIARY INFORMATION (Please Print)

Full Name of Beneficiary: _____ Relationship: _____

Address/Phone Number: (if different than above): _____

Your beneficiary is the person to whom the Plan's death benefit is to be paid. If you name more than one beneficiary, the death benefit will be evenly divided, unless otherwise specified.

MEMBER CERTIFICATION

I CERTIFY THAT THE INFORMATION PROVIDED TO THE H&W FUND ON AND WITH THIS FORM IS TRUE AND CORRECT.

_____ _____
Member Signature
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).
- If you are not married, but want to enroll your child or children on the Plan, a copy of either a related court order or your most recent IRS Income Tax return indicating the child as your dependent will also be 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.

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 provided with medical and prescription 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 Coverage

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

- The date your coverage as the employee ends.
- The date a divorce is finalized, for your spouse
- Your child's 19th birthday or 23rd birthday if enrolled as a full-time student
- Termination of full-time student status for your 19-23 year old child
- The date your child no longer meets the Plan's definition of a dependent

It is important that you notify the H&W Fund Office within 60 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 (Health and Welfare page) or requested from the Fund Office.