IUOE LOCAL 399
HEALTH AND WELFARE PLAN ENROLLMENT FORM

MEMBER INFORMATION (Please Print)

Name:____
Last First Middle Initial

Social Security Number: ___________ - ___________- ___________ Date of Birth: _____/_____/_____

Address: ____
Street City State Zip

Gender: ( ) M ( ) F Marital Status: ( ) Single ( ) Married

Contact Information

Home Phone: ( ) ____________________ Cell: ( ) ____________________ Work Phone: ( ) ____________________

Home Email: ____ Date Employed: ____/____/____

Employer Name: ______________________________ Job Site: ______________________________

OFFICE USE ONLY

Coverage Effective Date: _______ / _______ / _______ ID# 9399 _______ _______ _______ _______ _______

Notes: ____

DEPENDENT ENROLLMENT INFORMATION (Please Print)

Spouse Name (Marriage Certificate Required) Date of Birth Social Sec. No. Office Use Only

______________________________ _____/______/_____ ___________________ ☐

Does Your Spouse Have Group Insurance or Medicare? ( ) Yes ( ) No
(If yes, please complete reverse side)

Child Name(s): (Birth Certificate Required) Date of Birth Gender: Social Sec. No.

______________________________ _____/______/_____ ( ) M ( ) F ___________________ ☐

______________________________ _____/______/_____ ( ) M ( ) F ___________________ ☐

______________________________ _____/______/_____ ( ) M ( ) F ___________________ ☐

______________________________ _____/______/_____ ( ) M ( ) F ___________________ ☐

______________________________ _____/______/_____ ( ) M ( ) F ___________________ ☐

Do Any Of Your Children Have Other Group Insurance? ( ) Yes ( ) No
(If yes, please complete reverse side)

BENEFICIARY INFORMATION (Please Print)

HEALTH & WELFARE DEATH BENEFIT

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

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

A Marriage Certificate will be required by the Fund for purposes of covering your spouse.

A 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.

Coordination of Benefits Information

If you indicated on the reverse side that your spouse and/or adult child 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 ______________

Adult Child Employer: ______________________ Insurance Carrier: ______________

______________________ Insurance Carrier: ______________

______________________ Insurance Carrier: ______________

Type of Coverage: ( ) Medical ( ) Dental ( ) Vision ( ) Other ______________

Additional Notes: ______________________

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

If Yes, who ______________________

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

If Yes, who ______________________

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 (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