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, fax 262.549.3549

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:	Primary Phone Number:	Birth Date (MM/DD/YY):	

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	/ /	- -

Dependent Documentation/Proof

You must also enclose a copy of a Certified State or County 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. Hospital and church records are not 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 with this form.**

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 health coverage other than Operating Engineers? Yes ☐ No ☐

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

Effective date of other coverage:	Policy holder's name:	Type of other coverage: ☐ Family ☐ Single	Check types of other coverage: ☐ Medical/Rx ☐ Dental ☐ Vision

Is the other coverage a Health Savings Account (HSA)? Yes ☐ No ☐ . If yes, there will be no secondary medical or prescription drug coverage from this Fund. The IRS does not allow you to have a High Deductible Health Plan and an HSA Plan with our type of plan that is NOT a High Deductible Health Plan. Call the Fund Office for more information.

For children under age 18, are there court documents or custody paperwork for health insurance coverage? Yes ☐ No ☐. If yes, send a copy with this form.

Complete other side ➡

Spouse Information

Print Spouse's Last Name	Spouse's First Name	Spouse's Telephone Number

Is spouse Employed? ☐ Yes ☐ No ☐ Self Employed	If you answered "No" or "Self Employed", sign and date the form below.	**If the spouse is employed but is not eligible for other coverage, the spouse 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, the spouse will <u>not</u> be covered under this Plan for medical or prescription drugs.**

If the spouse previously had insurance from the spouse's employer and are either no longer employed or no longer eligible for the employer's coverage, please provide written documentation of the termination date of that other coverage. **If no documentation is provided, eligibility with this Fund will be reinstated as of the date the signed form is received by the Fund Office.**

Spouse's Employer Name and Address:	Spouse's Employer Telephone Number:

Does the spouse's employer offer health coverage/insurance to employees? ☐ Yes ☐ No	Effective date of existing coverage or date when the spouse will be eligible to enroll for health coverage/insurance under the employer's plan?

Does your spouse have other health coverage/insurance (besides Operating Engineers)? If yes, provide the following: ☐ Yes ☐ No	Name of other health coverage/insurance company:

Is the other coverage a Health Savings Account (HSA)? ☐ Yes ☐ No

If yes, there will be no secondary medical or prescription drug coverage from this Fund. In order to ensure that contributions to a health savings account are possible, the IRS does not allow you to have a High Deductible Health Plan and an HSA with our type of plan that is NOT a High Deductible Health Plan. Call the Fund Office for more information.

Type of other Coverage: ☐ Family ☐ Single	Check all that apply: ☐ Medical/Rx ☐ Dental ☐ Vision

Spouse Authorization

<u>All spouses must sign this section</u>. I certify that all of the information contained in this form is accurate and complete to the best of my knowledge. For working spouses, I authorize my employer, if any, 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, (the "Health Fund"). I understand that this authorization shall remain in effect as long as I am eligible for benefits under the Health Fund. I understand that the purpose and scope of this authorization is to allow the Health Fund to verify with my employer, if any, whether I am eligible to collect or obtain coverage under my employer's health plan. **I understand it is my responsibility to notify the Health Fund of any change in employment, coverage or the above-described information.** I further understand and acknowledge that, if I fail to disclose eligibility for, or enrollment in, my employer's health coverage/insurance plan, that coverage under the Health Fund will be retroactively terminated as of the date of eligibility or enrollment in my employer's health coverage/insurance plan, and I will be obligated to repay all claims paid by the Health Fund during the time I was eligible for, or enrolled in, my employer's health coverage/insurance plan to the extent allowed by law.

Spouse's Signature: _____ **Date:** _____

Death Benefit Beneficiary Designation

I 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 Health Fund 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:** _____