

International Union of Operating Engineers

Local Unions 181, 320 & TVA

Health & Welfare Trust Fund

700 North Elm Street, P.O. Box 1179, Henderson, KY 42419-1179

This form must be completed in its entirety before any claims can be paid for any family member.

Supporting documents will be required to add dependents.

Member's Name _____ Social Security # _____ - _____ - _____
Last First MI

Address _____
P.O. Box or Street City State Zip

Birth Date ____/____/____ Phone # (____) _____ Sex: Male _____ Female _____

Single _____ Married _____ Widowed _____ Divorced _____ Legally Separated _____ Date of Marriage _____

Death Benefit Beneficiary Designation _____ Relationship _____

Address of Beneficiary _____
P.O. Box or Street City State Zip

Beneficiary Social Security# _____ - _____ - _____ Birth Date ____/____/____ Phone# _____

List All Dependents Who Will Be Covered (Spouse and Children)

Supporting documents required (Marriage certificate, birth certificates, legal documents, etc.)

Name (First & Last)	M or F	Relationship	Social Security #	Birth Date
_____	_____	Spouse	____ - ____ - ____	____/____/____
_____	_____	_____	____ - ____ - ____	____/____/____
_____	_____	_____	____ - ____ - ____	____/____/____
_____	_____	_____	____ - ____ - ____	____/____/____
_____	_____	_____	____ - ____ - ____	____/____/____

IS MEMBER OR ANY DEPENDENT COVERED BY ANY OTHER GROUP PLAN OR MEDICARE (EXCEPT MEDICAID)?

No _____ Yes _____ (If yes, complete reverse side of this form)

I/We jointly certify that the information on this form is true and correct. I/We hereby authorize all doctors, pharmacists, hospitals or other institutions or organizations rendering care and treatment or utilization service to furnish this Plan or its utilization contractor with full information regarding treatment rendered (including copies of their records). I/We authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish this Plan with information regarding benefits to which I/We may be entitled. A photostatic copy of this authorization shall be considered as effective and valid original.

Member's Signature _____ Date _____

If you or any of your dependents are covered by any other group health plan, please complete the following information:

Name & Date of Birth of Policyholder _____

Names of all individuals covered by other Insurance _____

Name of Insurance Carrier _____

Address of Insurance Carrier _____

Policy # _____ Group # _____

Effective Date of Coverage _____ Family or Individual _____

Drug Card _____ If yes, name of Company _____

If you or any of your dependents are covered by Medicare, please complete the following information:

Name of Covered Person _____

Medicare # _____

Effective date of Part A _____

Effective date of Part B _____

If there are additional policies, or if more room is required, please use a blank sheet of paper.

Mail this completed form and documents to:

IUOE Health & Welfare
P.O. Box 1179
Henderson, KY 42419-1179
or
Email to:
healthandwelfare@iuoe181hw.org

For assistance, call our office at:

270-826-6750
or
toll free at 1-800-242-7076
or 1-800-626-7024