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 ____
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 ____
Street, City, State, Zip

Beneficiary Social Security# __________-________-__________ Birth Date __________/________/__________

Dependents (Include 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

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 doctor, 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 ______________

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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

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For assistance, call our office at:

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