

**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
_____	_____	_____	____ - ____ - ____	____/____/____
_____	_____	_____	____ - ____ - ____	____/____/____
_____	_____	_____	____ - ____ - ____	____/____/____
_____	_____	_____	____ - ____ - ____	____/____/____
_____	_____	_____	____ - ____ - ____	____/____/____

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 _____

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

Name 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**