

**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 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**