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 Legal Name ______________________________ Social Security # ______-______-______
Last First MI

Address ____
Street, City, State, Zip

Birth Date ____/____/____ Phone # (______) ____________________
Area

Male______ Female______ Single______ Married ______ Date of Marriage ______________

Name of Beneficiary ______________________ Relationship ______________

Address of Beneficiary ____
Street, City, State, Zip

Beneficiary Social Security# ______-______-______ Birth Date ____/____/____

Dependents (Include Spouse and Children)
Supporting documents required (Marriage license, 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 herby 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 photostat copy of this authorization shall be considered as effective and valid original.

Date ______________ Member's Signature ______________________________

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 to:

IUOE Health & Welfare
P.O.Box 1179
Henderson, KY 42419-1179

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For assistance call our office at:

1-800-242-7076 (in Kentucky)
1-800-626-7024 (outside Kentucky)
or
1-270-826-6750