# OPERATING ENGINEERS HEALTH & WELFARE FUND

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# ACTIVE ENROLLMENT FORM – UTAH

***CHECK ALL THAT APPLY:*** ☐ **NEW MEMBER** **CHANGE OF:** ☐ **NAME** ☐ **ADDRESS** ☐ **PLAN** ☐ **MARITAL STATUS** ☐ **DEPENDENTS**

## PARTICIPANT DATA - EMPLOYEE INFORMATION

**COMPLETE ALL INFORMATION – PLEASE PRINT IN INK**

| | | | |
|---|---|---|---|
| **LAST NAME** | **FIRST NAME** | **INIT.** | **SOCIAL SECURITY NUMBER** |
| **MAILING ADDRESS (STREET OR P.O. BOX)** | | **GENDER (M/F)** | **DATE OF BIRTH** |
| **CITY** | **STATE** | **ZIP** | **TELEPHONE NUMBER** ( ) |
| **EMAIL ADDRESS (REQUIRED)** | | | **UNION LOCAL** |
| MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED | | | DATE OF MOST RECENT MARRIAGE/DIVORCE |
| **OCCUPATION** | **EMPLOYER NAME AND ADDRESS** | | **DATE OF HIRE** |

***Any change in plans will be effective the first day of the second calendar month following the date the Trust Fund Office receives your enrollment form (per the Summary Plan Description).**

## FAMILY DATA

**PROVIDE THE SOCIAL SECURITY NUMBER OF EACH DEPENDENT YOU ENROLL. FEDERAL REGULATIONS REQUIRE HEALTH PLANS TO REPORT THE NAMES AND SOCIAL SECURITY NUMBERS OF EACH COVERED INDIVIDUAL TO THE IRS.**

**BEFORE ALLOWING A DEPENDENT TO BE ADDED TO THE PLAN, THE TRUST OFFICE REQUIRES ALL DOCUMENTATION SUCH AS MARRIAGE CERTIFICATE, BIRTH CERTIFICATE, DIVORCE, OR REMARRIAGE DOCUMENTS.**

| FULL NAME | RELATION* | GENDER (M/F) | DATE OF BIRTH | SOCIAL SECURITY NUMBER |
|---|---|---|---|---|
| PARTICIPANT | | | | |
| SPOUSE | | | | |
| DEPENDENT | | | | |
| DEPENDENT | | | | |
| DEPENDENT | | | | |

*Relation –Son, Daughter, Stepson, Stepdaughter, other.
"ELIGIBLE DEPENDENTS" are an Employee's lawful spouse and unmarried children from birth to age 26 with respect to all Fund benefits except Life Insurance for which the limiting age is 21. An eligible dependent child is the Employee's natural child, legally adopted child, stepchild, or foster child entirely supported by the employee.

## Additional Insurance Information

**List ANY dependent who is entitled to benefits from another group health care, insurance, or pre-paid medical plan:**

| | | |
|---|---|---|
| Dependent: | Insurance Company | Policy Number |
| Dependent: | Insurance Company | Policy Number |

**MEMBER SIGNATURE**_____ **DATE**_____