OPERATING ENGINEERS HEALTH & WELFARE FUND

1600 Harbor Bay Parkway, Suite 200✶Alameda, California 94502-3035
1-800-251-5014 ✶ FAX 510-863-8373

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).
- When you enroll in a plan option you must remain in the plan for at least 12 months. An exception will be made only if you elected an HMO and you move out of the HMO service area or it ceases to be available where you live (or the Board approves a change).

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 EVERY 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, DOMESTIC PARTNER 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

DATE:_____ **MEMBER SIGNATURE**_____

OFFICE USE ONLY
☐C ☐N/C
EFFECTIVE DATE: