Operating Engineers Local 101 Health and Welfare Fund

6601 Winchester, Suite 250, Kansas City, Missouri 64133
816-737-5959

Request for Information

MEMBER

Name _____ Social Security # _____

Address _____ Telephone # _____ Cell Phone # _____

Date of Birth _____ Email Address _____

☐Male ☐Female Retired? ☐Yes ☐ No

☐Single
☐Married Date _____
☐Divorced Date _____
☐Separated Date _____
☐Widowed Date _____

MEDICAL INSURANCE INFORMATION

Are you a policyholder of any other group medical plan? ☐Yes ☐ No If Yes, complete below information.

Health Insurance Coverage for: Self only ☐ Self and Spouse ☐ Self, Spouse & Child(ren) ☐

Medical Insurance Carrier Name _____ Phone # _____

ID Number _____ Effective Date _____ Employer sponsored? ☐Yes ☐ No

DENTAL INSURANCE INFORMATION

Are you a policyholder of any other group dental plan? ☐Yes ☐ No If Yes, complete below information.

Dental Insurance Coverage: Self only ☐ Self and Spouse ☐ Self, Spouse & Child(ren) ☐

Dental Insurance Carrier Name _____ Phone # _____

ID Number _____ Effective Date _____ Employer sponsored? ☐Yes ☐ No

SPOUSE

Name _____ Social Security # _____

Address _____ Telephone # _____ Cell Phone # _____

Date of Birth _____ Email Address _____ ☐Male ☐Female Retired? ☐Yes ☐ No

Employer Name _____ Telephone # _____ Retire Date _____

SPOUSE'S MEDICAL INSURANCE INFORMATION

Health Insurance Coverage: None ☐ Self only ☐ Self and Spouse ☐ Self, Spouse & Child(ren) ☐

Medical Insurance Carrier Name _____ Phone # _____

ID Number _____ Effective Date _____ Employer sponsored? ☐Yes ☐ No

SPOUSE'S DENTAL INSURANCE INFORMATION

Dental Insurance Coverage: None ☐ Self only ☐ Self and Spouse ☐ Self, Spouse & Child(ren) ☐

Dental Insurance Carrier Name _____ Phone # _____

ID Number _____ Effective Date _____ Employer sponsored? ☐Yes ☐ No

Please complete both sides of form

DEPENDENT CHILDREN (Definition found in Health and Welfare Plan SPD)

IMPORTANT: List **ALL** dependents under age 26.

Name	Social Security Number	Date of Birth	Relationship	**M**arried or **S**ingle?	Eligible for other group medical, vision or dental coverage?
				☐ M ☐ S	☐Yes ☐ No
Alternate address					
				☐ M ☐ S	☐Yes ☐ No
Alternate address					
				☐ M ☐ S	☐Yes ☐ No
Alternate address					
				☐ M ☐ S	☐Yes ☐ No
Alternate address					
				☐ M ☐ S	☐Yes ☐ No
Alternate address					

INSURANCE INFORMATION FOR DEPENDENT CHILD(REN)

If a dependent is covered by more than one policy, please provide information for each policy below or on a separate sheet of paper.

Other Insurance Coverage: Medical ☐ _____ Effective Date Dental ☐ _____ Effective Date

_____ _____

Medical Insurance Carrier Name Phone #

_____ _____ _____

Name of Policyholder Birth Date ID #

_____ _____

Dental Insurance Carrier Name Phone #

_____ _____ _____

Name of Policyholder Birth Date ID #

Please notify the Fund Office immediately in writing of any changes in the above information. Failure to do so will result in denial of claims.

I understand that if I or my dependents provide false information to the Operating Engineers Local 101 Health & Welfare Fund or conceal information, we could be subject to severe penalties under state and federal law and the Fund may seek to recover benefits wrongfully paid or pursue legal remedies against us. I declare and attest that the forgoing is true and correct.

_____ _____

Member's Signature Date