OPERATING ENGINEERS LOCAL #49
HEALTH AND WELFARE FUND
3001 Metro Drive, Suite 500
Bloomington, MN 55425
(952) 854-0795

APPLICATION FOR ENROLLMENT FOR DEPENDENT CHILD (AGES 19 THROUGH 25)

Complete this form for each eligible Participant's child.

- To apply for enrollment / re-enrollment as an eligible dependent under the Fund's Health Plan, complete and return this form to the plan administrator at the address noted above. A separate form must be used for each eligible dependent.
- If you have any questions, please contact the plan administrator at the address noted above.
- Enrollment will be effective 1st of the month in which this is received.

Participant's Name:________________________ SSN:________________

Participant's Address:________________________

Dependent's Name:________________________ SSN:________________

Dependent's Date of Birth:________________________

Dependent's Address:________________________

Is Dependent Employed?_____ If Yes, Name of Employer:________________________

Address of Dependent's Employer (if employed):________________________

Does Dependent have Insurance through employment?________

If Yes, Name of Insurance Company________________________

Telephone Number of Dependent's Employer (if employed):________________________

Is Dependent Married?_______ If Yes, Name of Spouse:________________________

Is Dependent's Spouse Employed?______ If Yes, Name of Employer:________________________

Does Dependent's Spouse have insurance coverage for the above dependent?_________

If Yes, Name of Insurance Company:________________________

Address of Dependent's Spouse's Employer (if applicable):________________________

Telephone Number of Spouse's Employer (if applicable):________________________

Please sign, date and return this form to the address noted above.

☐ YES, I am applying for enrollment / re-enrollment into the Operating Engineers Local #49 Health and Welfare Fund for the dependent listed above. You have our permission to contact the employer(s) listed above, if applicable for verification of health care coverage availability. I understand that if this information changes, it is our responsibility to notify the Fund Office immediately. The information I have provided is accurate and complete to the best of my knowledge.

Participant's Signature:________________________ Date:________________

Dependent's Signature:________________________ Date:________________