Operating Engineers Local #49 Health and Welfare Fund

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FAMILY UPDATE FORM

Complete this form to update the Fund Office, Wilson-McShane Corporation, of any changes regarding your dependents and their insurance coverage. When adding or removing dependents you must submit this form along with the required documentation listed on the reverse side of this form under "Life-Changing Events". When you first become eligible, you must complete this form to enroll your dependents in coverage from the Plan.

Insured's Data

Name:	Social Security Number:
Date of Birth	Phone Number:
Address:	Marital Status: ☐ Single ☐ Married ☐ Divorced Date of Marriage or Divorce:_____
Do you have other insurance? Yes ☐ No ☐ (If yes, please attach copy of other insurance ID card)	

Spouse's Data

Name:	Social Security Number:
Date of Birth	Phone Number:
Spouse's Employer Name:	Employer's Address:
Employer's Phone Number:	

Spouse's Insurance Data (you must include a copy of the front and back of the I.D. card for the other coverage)

Does your spouse have other Group Medical Coverage? ☐Yes ☐No	If yes, is the coverage type: ☐Single or ☐Family
Medical Insurance Carrier Name:	Insurance Carrier Phone Number:
Insurance Carrier Address:	Group Contract Number: Effective Date:_____ Term Date:_____
Does coverage include Dental? ☐Yes ☐No	Does coverage include Vision? ☐Yes ☐No

Dependent Child Information:

Make sure you fill out **ALL** the below information for each Dependent that is eligible for coverage from the Plan. **It is extremely important that you list each of your Dependent children that is under the age of 26.** If you have more than six eligible Dependents, please attach a separate sheet of paper with information regarding those additional Dependents and list your name at the top of that sheet of paper.

Dependent's Name	Relationship	Date of Birth	Social Security Number	Sex	Do they have other insurance?	Employer/Other Insurance (you must include a photocopy of the front and back of the I.D. card for the other coverage)
					Yes ☐ No ☐	
					Yes ☐ No ☐	
					Yes ☐ No ☐	
					Yes ☐ No ☐	
					Yes ☐ No ☐	
					Yes ☐ No ☐	

Do you want to change your beneficiary at this time?

- ☐ Yes, please send an Operating Engineers Local #49 Health & Welfare Fund Beneficiary Designation Form to me at the address listed above.
- ☐ No, I do not want to change my beneficiary at this time. I affirm the current named beneficiary is my intended beneficiary.

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Medicare Information

Is anyone eligible for the Operating Engineers Local #49 Health & Welfare Fund benefits also eligible for Medicare?

☐ Yes (Please complete this Medicare Information section below for Medicare eligible person(s))

☐ No (Please skip this Medicare Information section below)

Name:_____ Date of Birth _____ /_____ /_____ Medicare HIC #: _____

Effective Date: Part A: _____ /_____ /_____ Part B: _____ /_____ /_____ Relationship:_____

Medicare due to:

☐ End-stage renal disease and/or ☐ disability ☐ age Effective Date: _____ /_____ /_____

Name:_____ Date of Birth _____ /_____ /_____ Medicare HIC #: _____

Effective Date: Part A: _____ /_____ /_____ Part B: _____ /_____ /_____ Relationship:_____

Medicare due to:

☐ End-stage renal disease and/or ☐ disability ☐ age Effective Date: _____ /_____ /_____

If you are retired, please indicate retirement date: _____ /_____ /_____

Life-Changing Events

If you get married, provide the Fund Office with:
•A copy of your marriage certificate
•Your spouse's date of birth
•A copy of your spouse's medical insurance information, if he or she is covered under another plan

If you add a child, provide the Fund Office with:
•The birth date, effective date of adoption or placement for adoption, or the date of your marriage (for stepchildren)
•When you add a stepchild, you must submit a copy of your spouse's divorce decree to establish if there is other coverage for that child
•A copy of the birth certificate, adoption papers, court order, or marriage certificate (for stepchildren)
•A copy of your child's other medical insurance information, if he or she is covered under another plan
•Other information as may be requested by the Fund Office in order to demonstrate eligibility

If you get legally separated or divorced, provide the Fund Office with:
•A copy of your separation or divorce decree
•A copy of any QDRO
•If you have children for whom you do not have custody, a copy of any QMCSO

If your spouse wants to continue coverage, he or she must:
•Contact the Fund Office; and
•Enroll for COBRA Continuation Coverage

We are pleased to be of service to you. Please contact this office if you have any questions. **The following is extremely important information. Please read this language carefully and then sign and date this Family Update Form and return it to the Fund Office.**

I hereby certify that all information provided on this Family Update Form is correct to the best of my knowledge. I understand that if this information changes, it is my responsibility to notify the Fund Office immediately. I also understand that I will be required to reimburse the Plan for any payments made as a result of my failure to notify the Fund Office of a change in the information provided on this Family Update Form. Your Signature will also authorize an institution or physician to release information concerning your enrollment, related records and medical records to the fund office, if needed.

_____ _____

Participant's Signature Date of Signature