# International Union of Operating Engineers
# Local 487 Health & Welfare Fund

**911 Ridgebrook Road**
**Sparks, MD 21152-9451**
**Phone: 877-291-2387**
**www.associated-admin.com**

## ENROLLMENT APPLICATION

**Name of Employee**

| Last Name | First Name | MI | | OFFICE USE ONLY | |
|---|---|---|---|---|---|
| | | | | Effective | Terminated |
| Address | | | Local Union # | A. | |
| | | | | B. | |
| City | State | 9-digit Zip Code | | C. | |
| | | County: | | | |
| Telephone | Sex: M/F | Date Employed | | Date of Birth | |
| Your Social Security Number | Company, Job Classification | | | | |

Marital Status (Please Circle) Married Single Widowed Divorced Separated

Date of Marriage:

Coverage Desired: Individual Parent/Child Husband/Wife Family

Name of any other health insurance covering you, including Medicare

Policy # Name of Insurance: Employer:

Source of other coverage is:

Another job Spouse's plan Other, explain

If other coverage was declined, did you receive cash or benefit dollars for declining? Yes ☐ No ☐

If yes, please attach explanation.

Death Benefits to be paid to (Name/Relationship):

Beneficiary's Address

Date Signed Signature

**PLEASE READ BOTH SIDES OF FORM CAREFULLY**

I hereby apply for participation in the IUOE Local 487 Health & Welfare Fund. I understand that this application is subject to me being employed by a Participating Employer and covered by a collective bargaining agreement with a Participating Union. I agree to follow the rules and regulations as determined by the Board of Trustees as communicated to me through the IUOE Local 487 Health & Welfare Fund Summary Plan Description or updates thereto.

I certify that I have carefully read both sides of this enrollment form and agree to the terms specified thereon. The foregoing statements are complete, true, and correctly recorded.

Date_____ Signature (DO NOT Print)_____

MAIL COMPLETED FORM TO:
**IUOE Local 487**
**Health & Welfare Fund**
**911 Ridgebrook Road**
**Sparks, Maryland 21152**
**Telephone (877) 291-2387**

(over)

## LIST BELOW NAMES OF YOUR SPOUSE AND CHILDREN UNDER 26 YEARS OF AGE THAT YOU WISH TO ENROLL.

**(Under certain circumstances, dependent children up to age 30 may remain on their parent's insurance.)**

## A COPY OF YOUR MARRIAGE LICENSE AND/OR DEPENDENT'S BIRTH CERTIFICATE MUST BE INCLUDED WITH THIS APPLICATION

| LIST NAMES IN ORDER OF AGE – ELDEST FIRST | RELATIONSHIP | DATE OF BIRTH | SOCIAL SECURITY NUMBER |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Name any other health insurance covering your dependent(s):

Name_____Policy No_____

If coverage was declined on you or any dependent, did you or your dependent receive cash or benefit dollars for declining? Yes ☐ No ☐ If yes, please explain.

_____

_____

_____

**SPECIAL ENROLLMENT PROVISIONS**

**If you turned down coverage for either yourself or for your dependents** because you were covered under another group plan, and then that other coverage **ends, you may be able to enroll yourself and your dependents under the Fund, provided you do so within 30 days from the date your other coverage ended.** However, there are only a limited number of circumstances when you can enroll when you lose coverage. If the other coverage was COBRA coverage, you may request enrollment under this Fund only if the COBRA coverage is exhausted. For other group coverage that is not COBRA, you may request enrollment under this Fund if the other coverage was lost as a result of loss of eligibility or because employer contributions toward the other coverage ceased. You are not eligible to enroll under this provision if the other coverage was lost because you stopped paying premiums.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days from the date of marriage, adoption, placement for adoption, or 30 days prior to scheduled delivery date of childbirth.

**CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009**

Effective April 1, 2009, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for financial assistance under Medicaid or the State Children's Health Insurance Program ("CHIP"). However, to do so, you must request enrollment within 60 days of the date that CHIP or Medicaid assistance is terminated for you or your dependents.

In addition, effective April 1, 2009, you may be able to enroll yourself and your dependents in this Plan if you or your dependents become eligible to participate in a health insurance premium assistance program under Medicaid or CHIP. However, to do so, you must request enrollment within 60 days of the date you or your dependents are determined to be eligible for the premium assistance through Medicaid or CHIP.

To request special enrollment or to obtain more information, contact the Fund office at (877) 291-2387 and ask for the Eligibility Department.