HealthPlans
A HARVARD PILGRIM COMPANY

Enrollment / Change Form

Employer Name: ***Operating Engineers*** **Group Number:** ___ ___ ___

To Be Completed by Fund Office *(this section must be completed prior to submitting to Health Plans)*

Hire Date ____/____/____ Effective Date ____/____/____ Term Date ____/____/____ Change Eff. Date ____/____/____

Department/Division *(if applicable)*: _____

Please indicate: ☐ Active ☐ COBRA

Please indicate reason(s) for change or enrollment:

☐ New Employee ☐ Open Enrollment
☐ Change of Address ☐ Special Enrollment
☐ Add Dependent Coverage – Reason: _____ (if requesting coverage for employee's spouse ____/____/____) *date of marriage*
☐ Terminate Dependent Coverage – Reason: _____
☐ Change of Status – Reason: _____ ☐ Other: _____

To Be Completed by Employee

Employer Name					
Employee Last Name	***First Name***	***MI***	***Social Security Number***	***Date of Birth***	
Mailing Address	***City***	***ST***	***ZIP Code***	***Home Phone***	***Email Address***
Gender ☐ Male ☐ Female	***Marital Status*** ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated				

Health Coverage Election

Employee Only *or* **Employee + :**	**Spouse**	**Child(ren)**	**Family**	**Ex-Spouse***
☐ Medical	☐ Medical	☐ Medical	☐ Medical	☐ Medical
☐ Dental	☐ Dental	☐ Dental	☐ Dental	☐ Dental

**Note: Ex-spouses are not covered unless required by divorce decree. Full decree must be submitted to the Fund.*

Dependents

Last Name	***First Name***	***MI***	***Gender***	***Date of Birth***	***Relationship***	***Dependent Social Security Number (REQUIRED)***	***Add Dependent***	***Drop Dependent***
							☐	☐
							☐	☐
							☐	☐
							☐	☐
							☐	☐

Are you or any of your dependents covered by another ***medical*** plan? ☐ Yes ☐ No ☐ Self ☐ Spouse ☐ Children ☐ Ex-Spouse*
Are you or any of your dependents covered by another ***dental*** plan? ☐ Yes ☐ No ☐ Self ☐ Spouse ☐ Children ☐ Ex-Spouse*
If yes, Medical Policy No. & Insurance Co.: _____
If yes, Dental Policy No. & Insurance Co.: _____
Name and address of Spouse's or Ex-Spouse*'s Employer: _____

Election of Coverage

******Important***** **To accept coverage select YES, sign, and date this section.**

☐ **YES** • *I wish to elect coverage under The IUOE Local 877 & 70 Health and Welfare Fund for the coverages indicated above. I understand that my application will be subject to the terms of the Plan. I authorize any required deductions from my earnings. I authorize the release of medical records to Health Plans, Inc. or its representatives. A photocopy shall be as valid as the original. • I certify that the above information is accurate and complete and I am actively working the minimum number of hours required for coverage.*

Signature: _____ _____
Signature of Employee *Date Signed*

Waiver of Coverage

☐ **NO** • *If you are declining enrollment in the Plan for yourself and/or your dependents (including your spouse) because you and/or your dependents are covered under other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. 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 after the marriage, birth, adoption or placement for adoption.*

Signature: _____ _____
Signature of Employee *Date Signed*

rev. 11/21/2014

*****PLEASE RETURN COMPLETED FORM TO LOCAL 877 & 70 HEALTH AND WELFARE FUND*****