MIDWEST OPERATING ENGINEERS
FRINGE BENEFIT FUNDS

2022 Enrollment Form

Plan Year: April 1, 2022 to March 31, 2023

Midwest Operating Engineers
Fringe Benefit Funds Office
Health Plan Coverage
6150 Joliet Road
Countryside, IL 60525

INFORMATION ABOUT YOU

Member Name: (Last, First, Middle Initial, Suffix [e.g., "Jr."], if applicable)		Medical ID #:
Member Home Address		
Street:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	Email:
Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced		Date of Birth:

YOUR HEALTH PLAN OPTIONS

Health Plan Option: **Plan B-1 (Monthly) PPO**

Coverage Tier: ☐ Member Only ☐ Family

INDIVIDUALS TO BE COVERED*

	Name (Last, First, Middle Initial)	Social Security #	Sex		Birthdate (mm/dd/yyyy)	Disabled before age 26?**	
			Male	Female		Yes	No
Member			☐	☐		☐	☐
Spouse			☐	☐		☐	☐
Child			☐	☐		☐	☐
Child			☐	☐		☐	☐
Child			☐	☐		☐	☐
Child			☐	☐		☐	☐

** If you have more dependents, use the back of this form.*

*** If you have a dependent who is disabled and became disabled prior to age 26, please contact the Member Services Department at the Fund Office at 708-579-6600.*

If any of your dependents live at a different address than yours, please complete the following information for each of them:

Name(s)	Address(es)

Member Signature **Date**

By signing above, I certify that the information I have provided on this form is true and correct, and that I and my dependents listed on this form are entitled to the coverage I have chosen. I declare that all information and statements made herein are complete and true to the best of my knowledge. I understand that any misstatements or omissions may void all coverage applied for me and my dependents shown on this form.

The Fund follows procedures to protect the privacy of the health information of all plan participants. The health plan's Privacy Notice summarizes those procedures and is available to you and your dependents. If you or your dependents are interested in receiving a copy of the Notice, please contact the Fund Office.

INDIVIDUALS TO BE COVERED *continued*

	Name (Last, First, Middle Initial)	Social Security #	Gender		Birthdate (mm/dd/yyyy)	Disabled before age 26?*	
			Male	Female		Yes	No
Child			☐	☐		☐	☐
Child			☐	☐		☐	☐
Child			☐	☐		☐	☐
Child			☐	☐		☐	☐
Child			☐	☐		☐	☐
Child			☐	☐		☐	☐

* *If you have a dependent who is disabled and became disabled prior to age 26, please contact the Member Services Department at the Fund Office at 708-579-6600.*

REQUIRED DOCUMENTS FOR EACH DEPENDENT

If you are adding a dependent during the enrollment period, this form and the required documents (detailed below) must be received at the Fund Office during the enrollment period **(90 days from your initial eligibility Effective Date)** for the dependent's coverage to begin retroactively to your initial eligibility Effective Date, assuming the dependent can be validated by the Fund Office. The only exception is in the case of a birth, adoption, or placement for adoption. If you request coverage but fail to provide the required documents **within the required 90-day period**, enrollment will be effective the first of the month following the date in which all required documentation is received by the Fund Office. The required documentation must be received within a 12-month period from the date of birth.

Dependent Type	Required Documentation
Member	• County birth certificate • Social Security card
Spouse	• County Marriage Certificate • Spouse's Social Security Card • Spouse's County Birth Certificate • Spouse's employment information, if applicable • Spouse's other group insurance card, if applicable
Child or Stepchild	• County Birth Certificate • Social Security Card • Custodial Parent Questionnaire – Must be completed for stepchildren and/or natural children that do not reside in the member's household - copy of court order, if applicable • Completed ACEF - for Adult Dependent(s) only
Adopted Child	• Adoption letter or record showing date of adoption—signed and dated by a court official • County birth certificate • Social Security card