MIDWEST OPERATING ENGINEERS
FRINGE BENEFIT FUNDS

PENSION TRUST FUND • WELFARE FUND • RETIREE WELFARE PLAN
VACATION SAVINGS PLAN • RETIREMENT ENHANCEMENT FUND

6150 JOLIET ROAD, COUNTRYSIDE, IL 60525-3994 - PHONE (708) 482-7300
CLAIMS FAX (708) 482-7687 - ELIGIBILITY FAX (708) 352-3310 - PENSION FAX (708) 354-7732

JAMES M. SWEENEY, CHAIRMAN / DAVID M. SNELTEN, SECRETARY-TREASURER

Disabled Dependent Eligibility Review Form

INSTRUCTIONS: The following information is required to be completed to in order to determine whether your dependent qualifies as an eligible disabled dependent under the terms of the Midwest Operating Engineers Welfare Fund. Please complete the following information and provide the requested supporting documentation. **If you fail to complete the form in its entirety or do not provide all of the requested supporting documentation, then the eligibility review process for your dependent will be delayed.** If you have any questions regarding this form, please contact Member Services at (708) 579-6600 for assistance.

SECTION 1: MEMBER'S INFORMATION

MEMBER'S NAME:		UID#:		
STREET ADDRESS:	CITY:	STATE	ZIP:	TELEPHONE NO:

IS THE DEPENDENT CHIEFLY DEPENDENT UPON THE MEMBER FOR FINANCIAL SUPPORT AND MAINTENANCE?

YES ☐ NO ☐

IF YES, MEMBER MUST SUBMIT A COPY OF THEIR MOST RECENT FORM 1040 INDICATING THAT THE DISABLED DEPENDENT IS CLAIMED AS A DEPENDENT.

COPY OF FORM 1040 ATTACHED? YES ☐ NO ☐

SECTION 2: DISABLED DEPENDENT'S INFORMATION

DEPENDENT'S NAME:	DATE OF BIRTH:	RELATIONSHIP TO MEMBER:
MARITAL STATUS: SINGLE ☐ MARRIED ☐ If the disabled dependent is married, **do not complete** the remainder of the form and call Member Services.	ADDRESS (If different than member's):	
SEX: MALE ☐ FEMALE ☐	DATE OF DISABILITY:	NATURE OF DISABILITY:

HAS THE DEPENDENT BEEN DECLARED DISABLED BY THE SOCIAL SECURITY ADMINISTRATION? YES ☐ NO ☐

IF YES, YOU MUST ATTACH A COPY OF THE SSDI AWARD LETTER AND/OR MOST RECENT MONTHLY SSI STATEMENT.

COPY OF SSDI AWARD/RECENT SSI STATEMENT ATTACHED? YES ☐ NO ☐

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DOES DEPENDENT CURRENTLY HAVE OTHER/ADDITIONAL HEALTH INSURANCE (example: Medicare; Medicaid, Employer)
YES ☐ NO ☐

OTHER/ADDITIONAL HEALTH INSURANCE NAME:	OTHER HEALTH INSURANCE ID NUMBER:	OTHER INSURANCE EFFECTIVE DATE:

IS THE DEPENDENT EMPLOYED? YES ☐ NO ☐

IF YES, PLEASE COMPLETE THE FOLLOWING INFORMATION.

EMPLOYER NAME:

EMPLOYER ADDRESS:

EMPLOYER PHONE NUMBER:	TYPE OF EMPLOYMENT: Full-Time ☐ Part-Time ☐ If Part-time, number of hours per week:_____	DATE OF HIRE:

SECTION 3: MEMBER'S SIGNATURE

Member must sign the form to be valid and received by the Fund Office, with satisfactory proof of such incapacity within 31 days after the upper age limit (currently age 26) is reached.

- It is imperative that we have complete medical proof of your dependent's disability. This should be supplied by the physician(s) who treated your dependent during the entire period of disability.
- The inability to find employment or a reduction in work force is, of themselves, NOT evidence of eligibility for continuation of coverage.

I certify/attest that the dependent meets the following criteria:

1. The dependent became disabled before reaching the limiting age (currently age 26); and
2. The dependent is unmarried and incapable of self-sustaining employment due to disability; and
3. The dependent relies chiefly upon Member for support and maintenance.

My signature attests that the above statements are true and correct. If requested by the Fund Office, I can provide further substantiating documentation.

Member's Signature: _____

Date of Signature: _____

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SECTION 4: PHYSICIAN INFORMATION

The following must be completed, signed, and certified by a physician. A report or letter from the dependent's personal physician giving physician's opinion of the dependent's present health status and the prognosis is required with this completed form.

INFORMATION ATTACHED? YES ☐ NO ☐

PHYSICIAN'S NAME **(include Credentials)**:	PHYSICIAN'S CONTACT INFORMATION: PHONE: _____ FAX: _____

PHYSICIAN'S MAILING ADDRESS:

DATE OF DEPENDENT'S LAST EXAM:

(NOTE: The application date and the date of the exam MUST be within the past year)

DISABILITY STATUS: TEMPORARY ☐ PERMANENT ☐	100% DISABLED ☐ _____% PARTIALLY DISABLED ☐

DIAGNOSIS CAUSING DISABILITY (provide ICD-10 and standard nomenclature of condition):

PROGNOSIS:

WILL PATIENT BE CAPABLE OF SELF-SUPPORT? YES ☐ NO ☐

IF YES, PLEASE PROVIDE A DATE: _____

IF NO, PLEASE EXPLAIN, IN DETAIL, WHY THIS DEPENDENT IS UNABLE TO WORK IN GAINFUL EMPLOYMENT:

My signature attests that the above statements are true and correct. If requested by either the member or the Fund Office, I can provide further substantiating documentation.

Signature of Attending Physician: _____

Date of Signature: _____