MIDWEST OPERATING ENGINEERS
HEALTH & WELFARE INQUIRY FORM

Member Name: ______________________________ Date of Birth: ____________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

MOE ID: __________________________ Contact Number: ____________________

Address: ____

Spouse's Name: ______________________________ Date of Birth: ____________

Spouse's Employer Name: ____

Address: ____

IF THIS CLAIM IS FOR YOUR DEPENDENT

Dependent Name: ______________________________ Date of Birth: ____________

Relationship to Member: ☐ Spouse ☐ Son ☐ Daughter ☐ Other ____________

Is the Dependent Employed? ☐ Yes ☐ No If Yes, Employer Name: __________________

Address: ____

YOU OR DEPENDENT(S) HAVE OTHER GROUP INSURANCE

Insured's Name: ____

Insurance Type: ☐ PPO Plan ☐ HMO Plan ☐ Medicare

Insurance Company Name: ____

ABOUT THIS CLAIM

Describe sickness or injury: ____

Was the condition the result of an accident or injury? ☐ Yes ☐ No

If yes, please explain how and where, including the address, it happened: __________________

____

____

Date accident occurred or sickness began: ______________ Date first treated: ____________

Did condition occur in the course of employment? ☐ Yes ☐ No

MEMBER'S SIGNATURE

I certify that the above information is true and complete to the best of my knowledge. I authorize the release of all information regarding any injury, illness, or treatment related to myself or my dependents when requested by the Midwest Operating Engineers. A copy of this form is as effective/valid as the original.

______________________________ ____________

Member's Signature Date

CLM07
REV 09.2025