



MIDWEST OPERATING ENGINEERS ADULT DEPENDENTS COORDINATION OF BENEFITS FORM

This form must be completed in full and include each dependent over age 18. Please return it to the Funds Office as soon as possible, along with all required documentation. Failure to provide the requested information may delay processing of your Adult Dependent's claims.

MEMBER INFORMATION

Member Name:	MOE ID:
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ADULT DEPENDENT #1 INFORMATION

Adult Dependent Name:	Date of Birth:
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Employer Name:

Employer Address:

Does the Adult Dependent have health insurance through their employer? ☐ Yes ☐ No	Select all that apply: ☐ Medical ☐ Dental ☐ Vision
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Policyholder Name:	Effective Date of Their Benefits:
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ADULT DEPENDENT #1 OTHER COVERAGE

Is the Adult Dependent married?	☐ Yes	☐ No
If yes, does the Adult Dependent have health insurance through their spouse?	☐ Yes	☐ No
Has the Adult Dependent been awarded Social Security Disability benefits?	☐ Yes	☐ No
Is the Adult Dependent entitled to Medicare benefits?	☐ Yes	☐ No
Does the Adult Dependent have Medicaid?	☐ Yes	☐ No

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 statements and information 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 dependent(s). If you or your dependent(s) are interested in receiving a copy of the Notice, please contact the Funds Office at 708-579-6600.

ADULT DEPENDENT #2 INFORMATION

Adult Dependent Name:	Date of Birth:
Employer Name:	
Employer Address:	
Does the Adult Dependent have health insurance through their employer? ☐ Yes ☐ No	Select all that apply: ☐ Medical ☐ Dental ☐ Vision
Policyholder Name:	Effective Date of Their Benefits:

ADULT DEPENDENT #2 OTHER COVERAGE

Is the Adult Dependent married?	☐ Yes	☐ No
If yes, does the Adult Dependent have health insurance through their spouse?	☐ Yes	☐ No
Has the Adult Dependent been awarded Social Security Disability benefits?	☐ Yes	☐ No
Is the Adult Dependent entitled to Medicare benefits?	☐ Yes	☐ No
Does the Adult Dependent have Medicaid?	☐ Yes	☐ No

ADULT DEPENDENT #3 INFORMATION

Adult Dependent Name:	Date of Birth:
Employer Name:	
Employer Address:	
Does the Adult Dependent have health insurance through their employer? ☐ Yes ☐ No	Select all that apply: ☐ Medical ☐ Dental ☐ Vision
Policyholder Name:	Effective Date of Their Benefits:

ADULT DEPENDENT #3 OTHER COVERAGE

Is the Adult Dependent married?	☐ Yes	☐ No
If yes, does the Adult Dependent have health insurance through their spouse?	☐ Yes	☐ No
Has the Adult Dependent been awarded Social Security Disability benefits?	☐ Yes	☐ No
Is the Adult Dependent entitled to Medicare benefits?	☐ Yes	☐ No
Does the Adult Dependent have Medicaid?	☐ Yes	☐ No