Health Plans, Inc.

Enrollment Form

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

Operating Engineers	001AB9					per
Employer	Group No.	Division	Date Hired Full-Time	Effective Date	Occupation	Earnings

Please indicate reason for enrollment:

☐ New Employee ☐ Special Enrollment ☐ Change in Beneficiary ☐ change address

☐ add dependent coverage (if applying for coverage for your spouse_____) ☐ terminate dependent coverage
date of marriage

☐ Change of Status -Reason:_____ ☐ other:_____

You or your eligible dependents, if any, may not be covered if enrolled more than 30 days after the day you complete the waiting period for coverage.

To Be Completed by Member:

Please provide information about yourself:

Member Last Name _____ First Name _____ MI _____ Social Security No. _____ Date of Birth _____

Mailing Address _____ City _____ State _____ Zip _____ Home Phone _____

Employer _____ Division (if applicable) _____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated

Were you or your dependents covered under a prior insurance plan? ☐ Yes ☐ No If yes, please include your "Certificate(s) of Prior Coverage"

Coverage Election

Please indicate desired coverage:

Employee Coverage
☐ Medical
☐ Dental

Spouse Coverage
☐ Medical ☐ Dental

Children Coverage
☐ Medical ☐ Dental

Beneficiary _____ Relationship_____

Spouse and Children to be Covered — Ex-Spouses are not covered

Last Name	MI	First Name	M/F	D.O.B.	Relationship	Social Security No.	Employer/School (must include school's address for students 19 or older

Documentation may be required for determining eligibility of dependents

Are you or any of your dependents covered by another plan?

Medical ☐ Yes ☐ No ***If yes***, Policy No. & Insurance Co: _____ ☐ Self ☐ Spouse ☐ Children

Name and address of Spouse's Employer_____

Dental ☐ Yes ☐ No ***If yes***, Policy No. & Insurance Co: _____ ☐ Self ☐ Spouse ☐ Children

Name and address of Spouse's Employer_____

Election of Coverage

- I wish to elect coverage under my employer's benefit plan for the coverages indicated above. I understand that my application will be subject to the terms of the Plan requirements. 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.

Date _____ Member Signature _____

Waiver of Coverage

- I hereby waive any and all coverages not specifically elected for me and my dependents. If applying for coverage at a later date for me or my dependents, contract limitations and provisions may apply.
- Reason for waiving coverage:_____

Date _____ Member Signature _____

For HPI use only: RECD _____ DATE ENT _____ FND SPEC _____ POL ISS SPEC _____ SHP DATE _____