Mid Central Operating Engineers Health & Welfare
PO Box 9605
Terre Haute, IN 47808

NEW ELIGIBLES/ANNUAL CLAIM FORM

RECEIPT OF THIS FORM DOES NOT GUARANTEE BENEFIT ELIGIBILITY.
Failure to complete this form in full may result in delay of payment of your claims.

PARTICIPANT INFORMATION

PLEASE INDICATE IF YOU ARE: ☐ Active or ☐ Retired

Name: _____ Social Security No./MCO: _____

Address: _____

City, State, Zip: _____ Phone: _____

Date of Birth: _____ Local Union No.: _____

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widow/Widower

SPOUSE'S INFORMATION

Name: _____ Social Security No. : _____

Date of Birth: _____ Is your spouse employed? ☐ Yes ☐ No

Employer: _____

Employer's Address: _____ Employment Start Date: _____

City: _____ State: ____ Zip: _____ Employer's Phone: _____

OTHER INSURANCE INFORMATION FOR YOURSELF, SPOUSE OR DEPENDENT CHILDREN

Are you, your spouse, or dependent children insured under any other group hospital or medical plan, Medicare*, or Champus? ☐ Yes ☐ No **If yes, please provide complete insurance company, carrier, or plan information:**
Insurance Company, Carrier, or Plan Name: _____

Address: _____ Policy Number: _____

City: _____ State: ___ Zip: _____ Phone Number: _____

Primary Insured: _____ Primary Insured's ID Number: _____

Family members covered under other insurance. Check all that apply: ☐ Self ☐ Spouse ☐ Children
***If you or your spouse are eligible for Medicare, you must provide the Fund Office with a copy of your Medicare card(s) when submitting this form.**

DEPENDENT CHILDREN'S INFORMATION

Name: _____ Date of Birth: _____ Social Security No.: _____

Name: _____ Date of Birth: _____ Social Security No.: _____

Name: _____ Date of Birth: _____ Social Security No.: _____

Name: _____ Date of Birth: _____ Social Security No.: _____

It is fraudulent to fill out this form with information you know to be false or to knowingly omit important facts. Criminal and/or civil penalties can result for such an act. If any of the above information is untrue, I agree to reimburse the Mid Central Operating Engineers Health & Welfare Fund for any money it was induced to pay as a result of the information I provided.

Participant's Signature: _____ Date:

Spouse's Signature: _____ Date: