Mid Central Operating Engineers Health & Welfare Fund

PO Box 9605, Terre Haute, IN 47808 812-232-4384

Resuming Retiree Coverage Application

Retiree Information – Complete the following information:

Retiree Name Date of Birth

Social Security Number Phone Number

Address City State Zip Code

Election to resume Coverage – Check One:

_____ I want to begin/resume coverage for myself only
Date desired to resume coverage_____(must be at the beginning of a month)

_____ I want to begin/resume coverage for myself and my dependents
Date desired to resume coverage_____(must be at the beginning of a month)

_____ I want to begin/resume coverage for my suspended dependents
Date desired to resume coverage_____(must be at the beginning of a month)

Note: By signing you agree to adhere to all provisions of the retiree plan set forth by The Fund. To begin/resume coverage for dependents, the dependent must meet the Plan's definition of a dependent. Only dependents that were eligible when you initially retired and or elected the one time Opt Out are eligible to begin/resume coverage. New dependents may be enrolled by completing an application form requesting special enrollment; this application is subject to administrative approval. If you need an application, please contact the Fund. This application form requesting special enrollment must be provided to the administrator within 60 days of the date of the qualifying event (i.e., the marriage, birth, adoption, or placement for adoption). Please note if you are eligible for Medicare and are not enrolled in Part B, we will not allow any benefit. Please see page 21 of the Summary plan description.

Dependent Information: Provide the following information for each eligible dependent for whom coverage was suspended

Spouse's Name Social Security Number Birth Date

Dependent Name Social Security Number Birth Date

Dependent Name Social Security Number Birth Date

Resuming Retiree Coverage Application
(continued)

Other Health Coverage Information:

_____

Name/Address of other Insurance Carrier

Phone Number of other Carrier Policy Number and/or Group Number

_____Certificate of Creditable Coverage attached (Medical and Prescription)

Authorization

I/We choose to begin/resume coverage under the Mid Central Operating Engineers Health & Welfare Fund retiree program. I/We have attached proof of other coverage **(Certificate of Creditable Coverage for both Medical and Prescription)** from previous carrier. I/We understand written application to continue Retiree Coverage with the Fund must be submitted to the Fund Office **within 60 days following the date previous coverage ends**. By signing below, I understand that coverage will begin as soon as administratively possible and that I do not need to wait until the beginning of an eligibility period.

Member's Signature_____Date_____

Spouse's Signature_____Date_____

Dependant's Signature_____Date_____

Enclosure(s): Certificate of Creditable Coverage from previous Insurance Carrier