

OPERATING ENGINEERS LOCAL 513 FRINGE BENEFIT FUNDS
3449 HOLLENBERG DRIVE, SUITE 150
BRIDGETON, MO 63044

314-739-2973 or 800-511-0101

Fax: 314-338-3046 Email: staff@iuoe513benefits.org

ANNUAL VITAL INFORMATION FORM

MEMBER Information (Please Print)

Last: _____ First: _____ Middle: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Social Security Number: _____ Telephone Number: _____

Date of Birth: _____ Gender: (please circle one) Male Female
month/day/year

Marital Status: (please circle one) Single Married Divorced Separated Widowed

Date of Marriage/Divorce/Separation: _____
month/day/year

Current Status: (please circle one) Active Retired Disabled COBRA Surviving Spouse

Medicare Number

(This only applies when a member, a spouse, or a covered dependent is age 65 or older or on Medicare disability)

Member # _____ Spouse # _____ **Dependent #**
and Name _____

DEPENDENTS - (Please list ALL current and new (if any) dependents that are covered on the Plan – Including Spouse) –

Attach additional sheet if needed.

FULL NAME	RELATIONSHIP	BIRTH DATE	SOCIAL SECURITY NUMBER
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

BENEFICIARY (Death Benefits-Health and Welfare Only)

FULL NAME	RELATIONSHIP	SEX	BIRTH DATE	SOCIAL SEC. #
_____	_____	_____	_____	_____
ADDRESS	CITY	STATE	ZIP	
_____	_____	_____	_____	

I agree to notify the Benefit Office within 60 days of any changes to the above information. Further, I declare all the above information to true and accurate. I understand that stating fraudulent, false or misleading information or the omission of material information could be grounds for denial of benefits or the immediate institution of legal action for the recoupment of benefits should benefits have already been paid.

Member Signature: _____ Date: _____

COORDINATION OF BENEFITS INQUIRY

A. General Information

Participant Name: _____ Participant's SS# _____

B. Spouse Employment Information:

Spouse's Name: _____ Spouse's D.O.B. _____

Is Spouse employed? YES _____ NO _____ (If no, please skip to section E)

Does Spouse have insurance coverage through employer? YES _____ (If yes, section D must be completed).
NO _____

Spouse's Employer: _____

Type of coverage (circle all that apply) Medical Dental Vision Prescription

List covered dependents:

C. Dependent(s) Employment Information: IF YOU HAVE MORE THAN ONE DEPENDENT WHO IS EMPLOYED, PLEASE ATTACH ANSWERS TO THE QUESTIONS BELOW FOR EACH DEPENDENT.

Dependent's Name: _____ Dependent's D.O.B. _____

Is Dependent(s) employed? YES _____ NO _____ (If no, please skip to section E)

Is Dependent(s) eligible for insurance coverage through employer? YES _____ (If yes, section D must be completed)
NO _____

Dependent's Employer: _____

Type of coverage (circle all that apply) Medical Dental Vision Prescription

D. Information about Other Insurance Plan or Program:

Other Insurance Name: _____

Insurance Co. Phone #: (____) _____

Policy/Group Number: _____

Effective date of coverage: _____ Is insurance active (Y/N): _____

E. Member Statement:

The above information is true and accurate to the best of my knowledge and belief. I also am aware of the fact that I must notify the Benefit Office immediately should any of the dependents listed on my coverage become eligible for any other coverage.

Any materials submitted by myself or on behalf of any eligible person that contain a material alteration or forged or false information, including signatures, will be rejected. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers as a result of such material in any matter.

I understand that stating fraudulent, false or misleading information or the omission of material information could be grounds for denial of benefits or the immediate institution of legal action for the recoupment of benefits should benefits have already been paid.

Member Signature: _____ Date: _____