BeneSys Group: BAOO

Member Enrollment / Change Form

Employer Name: Operating Engineers **Group Number: AB9**

To Be Completed by Fund Office

Effective Date:______ Termination Date:______ Change Effective Date:______

Please indicate: ☐ Active ☐ Retiree

Please indicate the reason(s) for change or enrollment:

☐ New Employee ☐ Change of Address ☐ ☐

☐ Add Dependent Coverage – Reason:______ if requesting coverage for employee's spouse:______ *date of marriage*

☐ Terminate Dependent Coverage – Reason:______

☐ Change of Status – Reason:______ ☐ Other:______

To Be Completed by Member

Employee Last Name	*First Name*	*MI*	*Social Security Number (SSN)*	*Date of Birth*

Mailing Address	*City*	*State*	*ZIP Code*	*Primary Phone*

Date of Hire	*Gender*	*Marital Status*	*Email Address*	*Job Site*

Health Coverage Election

Includes Medical, Dental and Vision Coverage

Please indicate your coverage election(s): ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family ☐ Employee + Ex-Spouse*

** Employees must provide a divorce decree when requesting coverage for an ex-spouse. Please contact the Fund Office for further information.*

Dependents

A Birth Certificate is Required for All Dependent Children

Last Name	*First Name*	*MI*	*Gender*	*Date of Birth*	*Relationship*	*Dependent SSN (REQUIRED)*	*Add* Dependent	*Drop* Dependent	*Other Coverage?**
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐

** If you have indicated that any of your dependents listed above are keeping other active medical and/or dental coverage, please indicate:*

☐ Medical Coverage

Insurance Company:______

Policy#:______

Policyholder's Name:______

Name/Address of Policyholder's Employer:______

☐ Dental Coverage

Insurance Company:______

Policy#:______

Policyholder's Name:______

Name/Address of Policyholder's Employer:______

Election of Coverage

******Important****** **To accept coverage, select YES, sign, and date this section.**

YES • *I wish to elect coverage under my employer's benefit plan for the coverage indicated above. I understand that my application will be subject to the terms of the Plan. I authorize any required deductions from my earnings. I authorize the release of medical and/or dental 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.*

Signature: ______ ______

Signature of Employee *Date Signed*

***** PLEASE RETURN COMPLETED FORM TO LOCAL 877 & LOCAL 70 HEALTH AND WELFARE FUND *****

EMAIL COMPLETED FORMS TO: enrollmentdocs@benesys.com

MAIL TO: PO Box 4403, Troy, MI 48099-9998 FAX TO: 617-514-3090