OPERATING ENGINEERS LOCAL 501 SECURITY FUND

RETIREE HEALTHCARE APPLICATION

Retiree's Name: _____ SSN: _____

Spouse's Name: _____ SSN: _____

Address: _____
Street

_____
City State Zip

Phone Number: _____ I Have Retired or Plan to Retire On: _____

Name of Last Employer: _____ Last Day Worked: _____

Retiree Birth Date: _____ Spouse Birth Date: _____

Eligible For Medicare _____ Yes _____ No Eligible For Medicare _____ Yes _____ No

****If eligible for Medicare, please include a copy of Medicare card****

I would like to continue coverage for my Spouse:
_____ NO _____ YES If YES, Spouse Name: _____

Please be advised retiree benefits are only available to the member and their spouse. Dependent children are not covered, nor are any dependent spouses acquire after retirement.

I, _____, hereby apply to the Operating Engineers Local 501 Security Fund for participation in the Retiree Program.

I agree to notify the Administrator of the Fund in writing whenever I return to work in the industry.

I also agree that my participation is to be governed in all respects by the provision of the Fund, or as the same may hereafter be amended, and the making of any monthly payment by me in the amount and manner as established by the Fund.

_____ _____
Date Signature of Applicant

Mailing Address: P.O. Box 990 ◆ West Covina, CA 91793
Physical Address: 1050 Lakes Drive Suite 120 ◆ West Covina, CA 91790
8311 West Sunset Road Suite 250 ◆ Las Vegas, NV 89113
Phone 626·646·1079 ◆ Toll Free 800·320·0106 ◆ Facsimile 626·931-1368
www.oelocal501benefits.org ◆ staff@oelocal501benefits.org

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EMPLOYMENT HISTORY

Please list all employment in the Operating Engineers Local 501 in the last **10** years:

EMPLOYER	DATE HIRED	DATE TERMINATED	LOCAL UNION #

1. Are you receiving benefits under the Central Pension Fund?

_____ NO _____ YES If YES, Give Date of Approval: _____

2. What type of retirement were you approved for?

_____ NORMAL AGE RETIREMENT _____ DISABILITY RETIREMENT

PLEASE NOTE: YOU AND YOUR SPOUSE MUST ENROLL IN MEDICARE PART A AND PART B IN ORDER TO BE COVERED UNDER THIS PLAN ONCE YOU BECOME ELIGIBLE FOR MEDICARE.

_____ _____

Date Signature of Applicant

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