Operating Engineers Local No. 77
Trust Fund of Washington, D.C.
Health And Welfare Program

911 Ridgebrook Road
Sparks, Maryland 21152-9451
Telephone: (877) 850-0977
www.associated-admin.com

8400 Corporate Drive, Suite 430
Landover, Maryland 20785-2361
Telephone: (877) 850-0977
www.associated-admin.com

ENROLLMENT APPLICATION

Name of Employee

Last Name	First Name	MI	**OFFICE USE ONLY** **Effective**	**Terminated**
Address		Local Union #	**A.**	
			B.	
City	State		**C.**	
			9-digit Zip Code	
Telephone	Sex: M/F	Date Employed	Date of Birth	
Your Social Security Number	Company, Job Classification			

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Date of Marriage:

Coverage Desired: ☐ Individual ☐ Parent/Child ☐ Husband/Wife ☐ Family

Name any other health insurance covering you, including Medicare

Policy #: Name of Insurance: Employer:

Death Benefits to be paid to (Name/Relationship):

Beneficiary's Address:

Date Signed: Signature:

THIS IS NOT AN APPLICATION FOR DENTAL INSURANCE

PLEASE READ BOTH SIDES OF FORM CAREFULLY

I hereby apply for participation in the Operating Engineers Local No. 77 Health and Welfare Fund. I understand that this application is subject to my employment with a Participating Employer and to my being covered by a collective bargaining agreement with a participating union.

I agree to follow the rules and regulations as determined by the Board of Trustees and communicated to me through Operating Engineers Local No. 77 Health and Welfare Fund Summary Plan Description, and updates thereto.

I also agree that any physician, hospital or other provider that has made a diagnosis, rendered treatment or provided service in connection with any illness for which hospital, medical, or other health care claim is made is authorized to furnish you, upon request, full information and records related to the service. Such information will be confidential.

I certify that I have carefully read both sides of this application and agree to the terms specified. Information provided is complete, true, and correctly recorded.

Date _____ Signature (Do Not Print) _____

MAIL COMPLETED FORM TO:
OPERATING ENGINEERS LOCAL NO. 77
HEALTH & WELFARE FUND
8400 Corporate Drive, Suite 430
Landover, MD 20785-2361

(SEE REVERSE SIDE)

LIST BELOW NAMES OF YOUR SPOUSE AND UNMARRIED CHILDREN UNDER 26 YEARS OF AGE WHO ARE TOTALLY DEPENDENT ON YOU.

LIST NAMES IN ORDER OF AGE – ELDEST FIRST	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER

A COPY OF YOUR MARRIAGE LICENSE AND/OR DEPENDENT'S BIRTH CERTIFICATE MUST BE INCLUDED WITH THIS APPLICATION.

Name any other health insurance covering your dependent(s), including Medicare.

Name: _____Policy No.: _____

SPECIAL ENROLLMENT PROVISIONS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Fund Office at 1-877-850-0977.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009

Effective April 1, 2009, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for financial assistance under Medicaid or the State Children's Health Insurance Program ("CHIP"). However, to do so, you must request enrollment within 60 days of the date that CHIP or Medicaid assistance is terminated for you or your dependents.

In addition, effective April 1, 2009, you may be able to enroll yourself and your dependents in this Plan if you or your dependents become eligible to participate in a health insurance premium assistance program under Medicaid or CHIP. However, to do so, you must request enrollment within 60 days of the date you or your dependents are determined to be eligible for the premium assistance through Medicaid or CHIP.

MAIL COMPLETED FORM TO:

Operating Engineers Local No. 77 Health & Welfare Fund
Attn: Eligibility Department
8400 Corporate Drive, Suite 430
Landover, MD 20785-2361