



Operating Engineers Local 825 Fund Service Facilities

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Pre-Cert and PPO
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EMPLOYER TRUSTEES

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ADMINISTRATOR



UNION TRUSTEES

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JAMES McGOWAN
MATTY WHITE
JOHN WOOD

Dear Member:

Please complete the following information and return this form to the IUOE Local 825 Welfare Fund in the self-addressed, postage paid envelope enclosed.

Member's name and SSN: _____

Child's full name: _____

Child's date of birth (month/day/year): _____

Is your adult child covered under any other group health plan? Yes No

If "yes", please complete the following:

Policyholder's Name:	Policyholder relationship to Child <input type="checkbox"/> Self <input type="checkbox"/> Child's spouse	Policyholder Date of Birth:	Group and Policy #:
Insurance Company/Claims Administrator Name:	Address:		Phone #:
Effective Date of Coverage:			
Type of Coverage: (circle all that apply)			
Hospital	Medical	Prescription Drug	Dental Vision

*If the above coverage ceases, please forward a letter from the insurance company indicating date of termination.

Member's Signature

Date