



# Operating Engineers Local 825 Fund Service Facilities

65 Springfield Avenue, Second Floor  
Springfield, New Jersey 07081  
(973) 671-6800

Pre-Cert and PPO  
(800) 677-3237

## EMPLOYER TRUSTEES

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## UNION TRUSTEES

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ALEX KOLBASOWSKI  
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: (please send us a copy of the medical card front and back.)

Policyholder's Name:	Policyholder relationship to Child: <input type="checkbox"/> Parent <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