



Operating Engineers Local 825 Fund Service Facilities

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Pre-Cert and PPO
(800) 677-3237

EMPLOYER TRUSTEES

JACK KOCSIS, JR., CO-CHAIRMAN
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ADMINISTRATOR



UNION TRUSTEES

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JOSEPH A. GRACE, JR.
ALEX KOLBASOWSKI
JOHN WOOD

Dear Member:

Please complete the following information and return this form.

1. **Member's Name & SSN:** _____
2. **Member's Phone #:** (Home) _____ (Cell) _____
3. Will your spouse be retaining her/his maiden name? Yes No
If yes, please provide supporting documents.
4. Is your spouse currently eligible for Social Security Disability Benefits? Yes No
If yes, please provide a copy of the Social Security Disability Award Certification.
5. Is your spouse employed? Yes No. If "yes", please complete the following:
Your spouse's S.S. No: _____ Employer: _____
Address: _____
6. Is your spouse also covered under any group health insurance or group prepayment plan?
 Yes No
If "yes", please complete the following: Is this single or family coverage? Single Family

	YES	NO
Medicare	<input type="checkbox"/>	<input type="checkbox"/>
Medical	<input type="checkbox"/>	<input type="checkbox"/>
Hospital	<input type="checkbox"/>	<input type="checkbox"/>
Prescriptions	<input type="checkbox"/>	<input type="checkbox"/>
Vision	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>
Orthodontics	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>

Insurance Carrier: _____ Policy Number: _____

Effective Date: ____/____/____ Address: _____

Phone No: _____

Please submit a copy of each insurance card, both front and back, for each insurance checked above.

If your spouse insurance coverage has terminated, please forward a letter from her/his insurance carrier reflecting termination date.

Member's Signature

Date