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

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	☐	☐
Medical	☐	☐
Hospital	☐	☐
Prescriptions	☐	☐
Vision	☐	☐
Dental	☐	☐
Orthodontics	☐	☐
Psychiatric	☐	☐

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**