

GROUP INSURANCE QUESTIONNAIRE

(If you or any family member are covered by another group insurance, you **must** complete this form.)

Note: This form must be completed in full and signed by the Participant before it will be accepted as a valid record.

PARTICIPANT INFORMATION (See other side for spouse information)

Social Security Number	Last Name	First Name	Middle	<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address		City	State	ZIP Code

Are you covered by any other health plan as a participant or dependent? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please answer the following questions)	SOCIAL SECURITY NUMBER FOR YOU AND ALL OF YOUR DEPENDENTS <u>MUST</u> BE PROVIDED.
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Name of employer who provides this coverage	Employer's address	Employer's phone number:
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Are **you** also covered by Medicare? (Please attach a copy of your Medicare card when you return this form.)
 No Yes (If yes, please provide the effective date of your Medicare coverage _____).

Other Medical Insurance- **Important:** Please attach a copy of your other insurance card when you return this form.

Name of medical insurance carrier	Medical insurance carrier's address:	Insurance carrier's phone number:
Policy number:	Effective date:	Type of policy: <input type="checkbox"/> Group <input type="checkbox"/> Private <input type="checkbox"/> Retiree Plan
Type of medical plan: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> EPO <input type="checkbox"/> POS		

List your dependents who are covered by this medical policy:

Name	Social Security Number	If a step-child, who is the custodial parent?
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Other Dental Insurance - **Important:** Please attach a copy of your other insurance card when you return this form.

Name of dental insurance carrier	Dental insurance carrier's address:	Insurance carrier's phone number:
Policy number:	Effective date:	Type of policy: <input type="checkbox"/> Group <input type="checkbox"/> Private <input type="checkbox"/> Retiree Plan
Type of medical plan: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> EPO <input type="checkbox"/> POS		

List your dependents who are covered by this dental policy:

Name	Social Security Number	If a step-child, who is the custodial parent?
Name	Social Security Number	If a step-child, who is the custodial parent?
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I certify under penalty of perjury that to the best of my knowledge all information provided on this document is true, correct and complete.

Signature of Participant Required	Date
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SPOUSE INFORMATION (See other side for participant information)

Social Security Number	Last Name	First Name	Middle	<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address		City	State	ZIP Code

Is **your spouse** covered by any other health plan as a participant or dependent?
 No Yes (Please answer the following questions)

SOCIAL SECURITY NUMBER FOR YOU AND ALL OF YOUR DEPENDENTS MUST BE PROVIDED.

Name of employer who provides this coverage	Employer's address	Employer's phone number:
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Is **your spouse** also covered by Medicare? (Please attach a copy of your Medicare card when you return this form.)
 No Yes (If yes, please provide the effective date of your Medicare coverage _____).

Other Medical Insurance- Important: Please attach a copy of your other insurance card when you return this form.

Name of medical insurance carrier	Medical insurance carrier's address:	Insurance carrier's phone number:
Policy number:	Effective date:	Type of policy: <input type="checkbox"/> Group <input type="checkbox"/> Private <input type="checkbox"/> Retiree Plan
		Type of medical plan: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> EPO <input type="checkbox"/> POS

List your dependents who are covered by this medical policy:

Name	Social Security Number	If a step-child, who is the custodial parent?
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Name	Social Security Number	If a step-child, who is the custodial parent?
Name	Social Security Number	If a step-child, who is the custodial parent?

Other Dental Insurance - Important: Please attach a copy of your other insurance card when you return this form.

Name of dental insurance carrier	Dental insurance carrier's address:	Insurance carrier's phone number:
Policy number:	Effective date:	Type of policy: <input type="checkbox"/> Group <input type="checkbox"/> Private <input type="checkbox"/> Retiree Plan
		Type of medical plan: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> EPO <input type="checkbox"/> POS

List your dependents who are covered by this dental policy:

Name	Social Security Number	If a step-child, who is the custodial parent?
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Please return form to: Operating Engineers Health & Welfare Fund, PO Box 7067, Pasadena, CA 91109