Operating Engineers Local No. 428
Health and Welfare Trust Fund
P.O. Box 16200
Phoenix, AZ 85011-6200

Customer Service #:
(602) 650-8161
(800) 669-1909
FAX (602) 325-8616

Group No.: OET001

TO BE COMPLETED BY PARTICIPANT – ANSWER ALL QUESTIONS THAT APPLY AND SIGN

THIS FORM IS TO BE COMPLETED BY THE PARTICIPANT AND DEPENDENTS ONCE EVERY 12 MONTHS TO INFORM THE TRUST FUND OF CHANGES IN FAMILY STATUS OR THE ADDITION OF OTHER MEDICAL INSURANCE COVERAGE.

THIS INFORMATION REQUESTED WILL FACILITATE THE PAYMENT OF YOUR CLAIMS. IF OTHER INSURANCE IS INVOLVED, INFORMING THE TRUST FUND MAY SAVE YOU CERTAIN OUT-OF-POCKET EXPENSE THROUGH THE COORDINATION OF BENEFITS.

1. EMPLOYEE NAME	□ MALE □ FEMALE	DATE OF BIRTH	SOCIAL SECURTY NO.	□ ACTIVE □ RETIREE
2.YOUR ADDRESS (NO.& STREET) (CITY) (STATE) (ZIP CODE)			TELEPHONE # E-MAIL ADDRESS:	
3.DEPENDENTS NAME		SOCIAL SECURITY NO.	IS DEPENDENT EMPLOYED? □ YES □ NO	
4.NAME AND ADDRESS OF DEPENDENTS EMPLOYER		DEPENDENT DATE OF BIRTH	IF EMPLOYED: □ FULL-TIME □ PART-TIME	
5.**ARE YOU OR YOUR DEPENDENT INSURED UNDER ANY OTHER GROUP INSURANCE?**			□ YES □ NO	
IF YOU ANSWERED YES, PLEASE COMPLETE A, B, C, D, & E BELOW				
A. NAME OF COMPANY:			B. POLICY NUMBER:	
C. ADDRESS (NO. & STREET)		CITY	STATE	ZIP CODE
D. □ FAMILY COVERAGE □ SINGLE COVERAGE		EFFECTIVE DATE:		
E. TYPE OF COVERAGE: □ MEDICAL □ DENTAL □ VISION				

AUTHORIZATION

Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital, or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policy holder, employer or benefit plan administrator to provide Zenith American Solutions or an agent, attorney, consumer reporting agency or independent administrator, acting on Zenith American Solutions behalf, information concerning advice, care or treatment provided the patient, employee or deceased named below, including information relating to mental illness or use of drugs or alcohol. I also authorize the employer or benefit plan administrator to provide Zenith American Solutions with financial or employment related information. I understand this information will be used by Zenith American Solutions for the purpose of evaluating my claim for benefits, and I or any authorized representative will receive a copy of this signed form upon request.

I further authorize Zenith American Solutions to release the benefit plan administrator, a summary of claims incurred by me and my covered dependents for the purpose of verifying claims submitted under my plan of benefits. This authorization is valid from the date signed for the duration of the claim.

NAME OF PATIENT/PARTICIPANT (OR DECEASED)

SIGNATURE OF CUSTODIAL PARENT IF MEDICAL SUPPORT ORDER IS INVOLVED

SIGNATURE OF PATIENT/PARTICIPANT, AUTHORIZED REPRESENTATIVE OR NEXT OF KIN

DATE SIGNED (MONTH/DATE/YEAR)

IF PATIENT/EMPLOYEE IS UNDER 18 YEARS OR INCAPACITATED, PARENT OR GUARDIAN MUST SIGN. IF PATIENT/EMPLOYEE IS DECEASED, AUTHORIZED REPRESENTATIVE OR NEXT OF KIN MUST SIGN.

NOTICE TO ALL PARTIES

IT IS FRAUD TO KNOWINGLY FILL OUT THIS FORM WITH FALSE INFORMATION OR TO KNOWINGLY OMIT IMPORTANT FACTS. CRIMINAL AND /OR CIVIL PENALTIES CAN RESULT FROM SUCH ACTS.