Health & Welfare Fund
LOCAL 399

DEPENDENT CHANGE FORM
CHANGE OF BENEFICIARY FORM

IUOE • Local 399 Health & Welfare Fund • 2260 S. Grove Street • Chicago, IL 60616
Phone: (312) 372-9870 ***(Option 3)*** **• Fax: (312) 842-0291**

This form requires the identification and signature of the Member and can be delivered to the Health & Welfare Office in person, by mail or fax (see address or fax number above). You may request acknowledgement of receipt of this change form.

SECTION 1 – ADD A NEW SPOUSE (Attach Marriage Certificate)
This is to notify the Health & Welfare Fund that the following dependent **IS NOW ELIGIBLE** for the Plan:

NAME	BIRTHDATE	MARRIAGE DATE	SPOUSE SOCIAL SECURITY #

Does your new spouse have employer group coverage? ◉ YES ○ NO If **YES**, please complete reverse side.

SECTION 2 – ADD A NEWBORN OR CHILD (Attach Birth Certificate or provide when received)
This is to notify the Health & Welfare Fund that the following dependent **IS NOW ELIGIBLE** for the Plan:

NAME	BIRTHDATE	CHILD'S SOCIAL SECURITY #

Does this child have coverage with another plan? ○ YES ○ NO If **YES**, please complete reverse side.

I authorize Local 399 to publish my newborn child's name in the "new additions" section of their newsletter publication ○ YES ○ NO

SECTION 3 – DELETE AN EXISTING DEPENDENT (Provide Divorce Decree and ex-spouse's address if applicable)
This is to notify the Health & Welfare Fund that the following dependent **IS NO LONGER ELIGIBLE** for the Plan:

NAME & ADDRESS	RELATIONSHIP	REASON FOR TERMINATION	EFFECTIVE DATE

SECTION 4 – CHANGE OF BENEFICIARY
This is to notify the Health & Welfare Fund of **a change in beneficiary to the death benefit under Local 399's Health & Welfare Plan**:

NAME	BIRTHDATE	RELATIONSHIP	ADDRESS / PHONE #

If more than one beneficiary is designated, settlement will be made in equal shares unless otherwise provided above. If no designated beneficiary survives the member, settlement will be made to the estate of the member.

SECTION 5 – LOCAL 399 DEATH BENEFIT
I designate the same beneficiary for **BOTH** my Health & Welfare death benefit and my Local 399 member death benefit: ○ YES ○ NO
If NO, please designate beneficiary below for my LOCAL 399 DEATH BENEFIT only:

NAME	BIRTHDATE	RELATIONSHIP	ADDRESS / PHONE #

I certify that all information provided to the Fund Office on this form is correct and that the beneficiary listed above was designated by me on this date.

_____ Member Name (Please Print)

_____ Signature of Member

_____ / _____ / _____ Member Social Security No.

(_____) _____ Primary Phone Number

_____ Date

For Office Use Only

Birth Certificate Received _____ Marriage Certificate Received _____ SPD Provided _____

Divorce Decree Received _____ COBRA Sent _____ ID # 93990 ___ - ___ - ___ - ___

COORDINATION OF BENEFITS

Please complete this side if you are enrolling a family member who has other insurance

You and other members of your household may be covered by more than one health insurance or dental plan. Coordination of benefits is a way to coordinate your health and welfare benefits when dual coverage exists. With current information on file, your claims will not be unnecessarily delayed.

Please Note:

- *Your primary coverage as the member is generally Local 399's Plan.*
- *Coverage under your spouse's employer is generally secondary for you.*
- *If you have eligible dependent children covered by dual plans, the coverage of the parent whose birthday falls first in the calendar year is generally considered the primary plan and the coverage of the other parent is generally secondary.*
- *If you have an adult child with coverage through their own employer, that coverage is primary for the adult child.*

For detailed coordination of benefits plan provisions, please refer to your Summary Plan Description (SPD).

Coordination of Benefits Information

If you indicated on the reverse side that your spouse and/or adult child has other individual or family coverage through an employer group plan, please provide details below:

Spouse Employer: _____ Insurance Carrier: _____

Family Members Covered: ( ) All ( ) Spouse Only ( ) Other _____

Adult Child Employer: _____ Insurance Carrier: _____

_____ Insurance Carrier: _____

_____ Insurance Carrier: _____

Type of Coverage: ( ) Medical ( ) Dental ( ) Vision ( ) Other _____

Additional Notes: _____

Do you, the member have other coverage through a current or past employer? ( ) Yes ( ) No

If Yes, who _____

Are you or any member(s) of your family eligible for Medicare due to age or disability? ( ) Yes ( ) No

If Yes, who _____