

OPERATING ENGINEERS HEALTH & WELFARE TRUST FUND FOR COLORADO
ADMINISTRATIVE OFFICE
P. O. BOX 564 ARVADA, CO 80001-0564 PHONE 303-412-9021
ENROLLMENT FORM

Please complete both sides of the form, sign, and return this form to the Plan Office for coverage. Print all information.

Employee Information

Employee Full Name: _____ Employee SSN: _____
Address: _____ Home Phone #: _____
City: _____ State: _____ Zip Code: _____ Alternate Phone #: _____
Date of Birth: _____ Marital Status: Single Married Divorced Widowed Gender: Male Female
Date of Marriage: _____ Date of Divorce: _____

Dependent Information

Use this section to list all eligible dependents. (Attach an additional page if necessary and provide all information). If you are enrolling a dependent who was not previously covered by the Plan, you must submit a copy of the required verification documents with your form. If you do not know which documents to submit, you may contact the Plan Office at 303-412-9021 for a list of the required documents.

Complete the following questions for each dependent:

Spouse

Full Name: _____ Spouse SSN: _____
Date of Birth: _____ Gender: Male Female Is your spouse employed? No Yes. If yes, please provide the following:
Employer Name: _____ Phone #: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Dependent Child

Full Name: _____ Dependent SSN: _____
Date of Birth: _____ Gender: Male Female
Relationship to Employee: Natural Child Adopted Child Stepchild Other _____ Full-Time Student No Yes
Address (if different address than participant): _____
City: _____ State: _____ Zip Code: _____
Is your dependent married? No Yes

Dependent Child

Full Name: _____ Dependent SSN: _____
Date of Birth: _____ Gender: Male Female
Relationship to Employee: Natural Child Adopted Child Stepchild Other _____ Full-Time Student No Yes
Address (if different address than participant): _____
City: _____ State: _____ Zip Code: _____
Is your dependent married? No Yes

Dependent Child

Full Name: _____ Dependent SSN: _____
Date of Birth: _____ Gender: Male Female
Relationship to Employee: Natural Child Adopted Child Stepchild Other _____ Full-Time Student No Yes
Address (if different address than participant): _____
City: _____ State: _____ Zip Code: _____
Is your dependent married? No Yes

Dependent Child

Full Name: _____ Dependent SSN: _____
Date of Birth: _____ Gender: Male Female
Relationship to Employee: Natural Child Adopted Child Stepchild Other _____ Full-Time Student No Yes
Address (if different address than participant): _____
City: _____ State: _____ Zip Code: _____
Is your dependent married? No Yes

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Other Health Coverage Information

If you, your spouse, or any of your dependent children have other medical coverage, you must complete this section and provide the requested information.

Covered Individual's Name	Other Coverage	Insurance Company Policy/ID#	Effective Date

If you or a dependent are eligible to enroll in Medicare, complete the following: Effective Date

Enrollee's Name	Medicare/Medicaid ID #	Part A	Part B	Part D	ESRD Onset

Beneficiary Designation for Death Benefits (Effective upon receipt by the Plan Office)

Primary Beneficiary(ies): I, the undersigned, hereby revoke any and all prior beneficiary designations made by me with respect to the Operating Engineers Health and Welfare Trust Fund for Colorado and hereby direct that any benefits payable under the Plan upon my death be paid to the following primary beneficiary (or equally to the following primary beneficiaries).

Name	Social Security No.	Relationship	Address	Phone Number

Contingent Beneficiary(ies): In the event all of the above named beneficiaries die or disclaim before the full amount of benefits, if any, has been paid, I direct that my entire remaining interest in the Operating Engineers Health and Welfare Trust Fund for Colorado be paid to the following contingent beneficiary (or equally to the following contingent beneficiaries).

Name	Social Security No.	Relationship	Address	Phone Number

All of the above items must be complete and you must sign below to verify that all of the information on this form is correct.

Employee Authorization

I understand that this election will remain in effect and may only be changed if I experience a HIPAA Special Enrollment Event, or for dependents not covered, if I follow the Plan's Rolling Enrollment procedures. I hereby certify that the foregoing information, to the best of my knowledge and belief, is true, correct and complete. I understand any willfully false statement on this form is a federal crime that is punishable by fine or imprisonment. I also understand that any fraud or intentional misrepresentation of material fact may result in my and/or my dependent ('s) (s') retroactive termination from coverage.

Employee Name (print): _____

Employee's Signature: _____ Date: _____

OPERATING ENGINEERS HEALTH AND WELFARE TRUST FUND FOR COLORADO

5511 West 56th Avenue, Suite 250, Arvada, Colorado 80002 Mailing Address: P.O. Box 564, Arvada, Colorado 80001-0564 303-412-9021



Dear Participant,

In order to comply with the Dependent Verification Audit you must review the list below of required documents and provide the documents for each dependent who is listed on your coverage letter enclosed in this packet. In addition, if you have any additional dependents that were not listed on the letter that you wish to have covered you must list them on your enrollment form and also provide the required documents for each of them. **Please provide copies of the documents listed on the following pages.** If you have any questions or need more information, please call the Plan Office at 303-412-9021.

How to Submit Required Documentation	How to Submit a Copy of a Federal Tax Return	Resources to Obtain Documents
<ul style="list-style-type: none"> To avoid processing delays, write your name and the participant's Social Security Number or member ID number provided in the enclosed letter that starts with U112-..... and write this number on the top right hand corner of each document you submit. Send copies only. No originals. Birth Certificates, Marriage Licenses, and other official documents are to be copied and submitted on a single sheet, one-sided. The back side is to remain blank. Each participant should submit his or her own documentation for him or herself and his or her dependents. Do not submit documentation on behalf of other participants. This will protect the confidentiality of the documents. Whether you are faxing or mailing the required documents, make sure each document is copied on its own separate page. (For example, if you are submitting a Marriage Certificate for your spouse and a Birth Certificate for your child, the Marriage Certificate should be copied onto one page and the Birth Certificate onto a second page.) For speedy processing, do not staple, tape or clip your documents. 	<p>Please use a black marker to hide financial and Social Security Numbers on the tax return before submitting it. Please note that it is a felony to falsify IRS tax forms in any way.</p> <p>Specific information required:</p> <ul style="list-style-type: none"> You and your spouse's full name Your complete address Social Security Number marked out for you and your dependents Filing status Exemptions (dependents) Dependent's(s) relationship to you 	<ul style="list-style-type: none"> Marriage Licenses & Birth Certificates: http://www.cdc.gov/nchs/w2w.htm (click on your state for details) Affidavit of Common Law Marriage: Contact the Plan Office Children born outside the United States: http://travel.state.gov/passport/get/first/first_825.html IRS Transcripts: Contact the IRS at 1-800-908-9946 or order a copy online at: http://www.irs.gov/individuals/article/0,,id=232168,00.html. A transcript provides the same information as a copy of a tax return, but does so more quickly. Transcripts provide taxpayers with a computer-created record of their tax return which includes most of the line-items as filed with the IRS, including any accompanying forms and schedules. The transcript does not reflect any changes the taxpayer, his/her representative, or the IRS made after the return was filed.

If you have questions, please call the Plan Office at 303-412-9021.

Spouse

A current legal spouse (including a legally separated spouse), as recognized by state law of your primary residence. An ex-spouse is not an eligible dependent.

Marriage Certificate

AND ONE of the following documents to show marriage is still current (use a black marker to hide financial information and Social Security Numbers):

- Page 1 and signature page of participant's Federal Income Tax Return (1040, 1040A or 1040EZ) from the prior year as filed with the IRS listing the spouse
- Page 1 and Certificate of Electronic Filing or transmission page of participant's Federal Income Tax Return (1040, 1040A or 1040EZ) from the prior year as filed with the IRS listing the spouse
- IRS Transcript of participant's Federal Income Tax Return (1040, 1040A, or 1040EZ) from the prior year. To obtain a copy you can contact the IRS at 1-800-908-9946 or order a copy online by visiting the following IRS website: <http://www.irs.gov/individuals/article/0,,id=232168,00.html>
- Current mortgage statement, home equity loan, or lease agreement listing both participant and spouse
- Current Property Tax documents listing both participant and spouse
- Automobile registration that is currently in effect listing both participant and spouse
- Current credit card or account statement listing both participant and spouse
- Current utility bill listing both participant and spouse
- Current utility bill listing the spouse at the same address as the participant

* Note: *Current is defined as within the last 12 months*

Common Law Spouse

A current professed marriage as husband and wife by common law in the State of Colorado.

Affidavit of Common Law Marriage (This form can be obtained by calling the Plan Office)

AND ONE of the following documents to show marriage is still current (use a black marker to hide financial information and Social Security Numbers):

- Page 1 and signature page of participant's Federal Income Tax Return (1040, 1040A or 1040EZ) from the prior year as filed with the IRS listing the common law spouse
- Page 1 and Certificate of Electronic Filing or transmission page of participant's Federal Income Tax Return (1040, 1040A or 1040EZ) from the prior year as filed with the IRS listing the common law spouse
- Transcript of participant's Federal Income Tax Return (1040, 1040A, or 1040EZ) from the prior year. To obtain a copy you can contact the IRS at 1-800-908-9946 or order a copy online by visiting the following IRS website: <http://www.irs.gov/individuals/article/0,,id=232168,00.html>
- Current mortgage statement, home equity loan, or lease agreement listing both participant and common law spouse
- Current Property Tax documents listing both participant and common law spouse
- Automobile registration that is currently in effect listing both participant and common law spouse
- Current credit card or account statement listing both participant and common law spouse
- Current utility bill listing both participant and common law spouse
- Current utility bill listing the common law spouse at the same address as the participant

* Note: *Current is defined as within the last 12 months*

Natural Child, Stepchild, Adopted Child or Child Placed for Adoption Up to Age 26

A natural child, stepchild, adopted child or child placed for adoption qualifies as a dependent until the last day of the month in which he or she turns age 26 whether married or unmarried.

Birth Certificate (issued by a state, county, or a vital records office)

AND ONE of the following legal documents for Adopted Child and Child Placed for Adoption Only:

- Certificate of adoption (court documents) signed by a judge showing that the participant has adopted the child
- Papers from the adoption agency showing intent to adopt
- International adoption papers from country of adoption

AND ONE of the following for Stepchild

- Document proving Stepchild/Stepparent relationship (a Stepchild must be the Child of the Eligible Employee, Retiree or Qualified Beneficiary's lawful spouse).

Grandchild Up to Age 19 for Whom the Participant is Legal Guardian

A never-married grandchild for whom the participant has been awarded custody and control by letters of guardianship or other legal process that results in the participant being legally responsible to provide support and maintenance for the grandchild. A grandchild for whom the participant has been awarded custody ceases to qualify as a dependent at the end of the month in which he or she turns age 19 (or, if a full-time student, age 23).

Court documents signed by a judge

AND documents showing that you are legally responsible for support and maintenance (if not indicated by court documents)

AND ONE of the following if child is a full-time student age 19 and over:

- A letter from the registrar with the dependent's name, semester and number of units enrolled, and school phone number
- A transcript with the dependent's name, school name, semester and number of units enrolled, and school phone number
- Full-Time Student Verification Form

Disabled Child

A participant's dependent child who is incapable of self-sustaining employment by reason of a mental or a physical impairment, disability or other condition which substantially limits one or more major life activities provided the incapacity began before the limiting age and the child is dependent on the participant for support and maintenance. The participant must submit proof of incapacity within 31 days of the date the dependent's coverage would otherwise terminate.

You must submit the required document(s) for one of the dependent categories as noted above, as proof that the dependent is your or your spouse/common law spouse's child.

AND ONE of the following documents:

- A medical certificate of disability
- Notice of Determination from the Social Security Administration

Please be advised that providing false or misleading information in order to obtain coverage for dependents is a federal crime that is punishable by fine or imprisonment. It may result in the termination of your health benefits coverage. The Board of Trustees may seek to recover all claims paid during the period that the ineligible dependent was covered.