MIDWEST OPERATING ENGINEERS FRINGE BENEFIT FUNDS
WELFARE FUND • PENSION TRUST FUND • VACATION SAVINGS PLAN
6150 JOLIET ROAD • COUNTRYSIDE, IL 60525-3994 • (708) 482-7300 • FAX (708) 482-7687
JAMES M. SWEENEY, CHAIRMAN JOHN E. KENNY, JR., SECRETARY-TREASURER

NAME OF MEMBER: ______________________________ Date of Birth: ______________

Marital Status: Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated ❑

Social Security Number: ______________________ Telephone Number: (_____) ______________

Home Address: ____

Spouse's Name: ______________________________ Date of Birth: ______________

Spouse's Employer Name: ____

Address: ______________________________ Telephone Number: (_____) ______________

IF THIS CLAIM IS FOR YOUR DEPENDENT

NAME OF DEPENDENT (FIRST): ___________ LAST: _______________DATE OF BIRTH: ______________

RELATIONSHIP TO MEMBER: WIFE ❑ Son ❑ Daughter ❑ Other ❑

Is Dependent Employed? Yes ❑ No ❑

If Yes, Provide Employer Name: ____

Address: ____

City, State, Zip: ____

IF YOU OR YOUR DEPENDENT HAVE ANY OTHER GROUP INSURANCE

INSURED NAME: ____

TYPE: INSURANCE ❑ Medicare ❑ Health Maintenance (HMO) ❑

Insurance Company Name: ____

ABOUT THIS CLAIM

* DESCRIBE SICKNESS OR INJURY: ____
* WAS THE CONDITION THE RESULT OF AN ACCIDENT OR INJURY: Yes ❑ No ❑
* If yes, tell us how and where (address) it happened: ______________________________

____

____

* Date accident occurred or sickness began: ______________ Date first treated: ______________
* Did condition occur in the course of employment? Yes ❑ No ❑

MEMBER'S SIGNATURE

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release by the Health and Welfare Fund, of any facts concerning the injury, illness, or treatment of myself or my dependents. A photocopy of this authorization shall be considered as effective and valid as the original.

☒ Member's Signature:

______________________________Dated:______________________

I AUTHORIZE PAYMENT OF BENEFITS TO THE PROVIDER(S)

☒ Member's Signature: ____

(Spouse cannot sign)

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