Operating Engineers Local 825 Fund Service Facilities

65 Springfield Avenue, Second Floor
Springfield, New Jersey 07081
(973) 671-6800

Pre-Cert and PPO
(800) 677-3237

Dear Member:

Please complete the following information and return this form to the IUOE Local 825 Welfare Fund in the self-addressed, postage paid envelope enclosed.

Member's name and SSN: _____

Child's full name: _____

Child's date of birth (month/day/year):_____/_____/_____

Is your adult child covered under any other group health plan? ☐ Yes ☐ No
If "yes", please complete the following: (please send us a copy of the medical card front and back.)

Policyholder's Name:	Policyholder relationship to Child: ☐ Parent ☐ Self ☐ Child's spouse	Policyholder Date of Birth:	Group and Policy #:
Insurance Company/Claims Administrator Name:	Address:		Phone #:
Effective Date of Coverage: / /			
Type of Coverage: (circle all that apply) Hospital Medical Prescription Drug Dental Vision			

*If the above coverage ceases, please forward a letter from the insurance company indicating date of termination.

_____ _____

Member's Signature **Date**