International Union of Operating Engineers Local 132
Health and Welfare Fund

P.O. Box 2626 Huntington, West Virginia 25726-2626
(304) 525-0482 1-800-642-3525 www.iuoe132.org

ENROLLMENT FORM

Name: _____
Participant's Name ID Number or SSN

Address: _____
Street City State Zip Code

_____
Participant's Date of Birth Home Phone Number Cell Phone Number Email

_____
Home Local Number Original Initiation Date Registration Number

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widower

Gender: ☐ Male ☐ Female

Are you or your spouse covered by any other Plan or insurance carrier? ☐ Yes ☐ No

If yes, complete the following:

(Check All That Apply)

☐ Group ☐ Single
☐ Individual ☐ Family
☐ Medicare ☐ COBRA
☐ Medicaid

Name of Insured _____
Name of Insurance _____
Policy Number _____
Insurance Phone Number _____
Effective Date of Coverage _____
Do you have prescription coverage? ☐ Yes ☐ No

Print the name of each dependent below. If you have no dependents write "NONE". Dependents are your spouse (copy of Marriage Certificate is required) and all children under nineteen (19) years of age. The Fund has extended coverage to adult children to age twenty-six (26), provided they are not entitled to medical coverage through their own employer.

Copy of Birth Certificate(s) is required for each Dependent listed below.

List Names in order of Age Oldest First	Social Security Number	Date of Birth Month / Day / Year	Relationship
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

I hereby authorize the release to or by the IUOE Local 132 Health & Welfare Fund for any medical or insurance information required to process claims submitted on my behalf or the behalf of any of my dependents listed above. A photocopy of this information may be honored.

I hereby declare the information I have provided is true and correct to the best of my knowledge. I understand that a false statement may disqualify me from benefits and that the Fund has the Right to Recovery from any Participant, any payments made as a result of misrepresentation, mistake or error, irrespective of the party causing such mistake or error.

I understand it is my responsibility to notify the Fund Office immediately should my spouse or dependent child(ren) become eligible with another insurance carrier or Plan.

➔ _____ ➔ _____
Participant's Signature Date

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HEALTH & WELFARE FUND

Beneficiary Designation Form

Participant Information

Name: _____ ID Number or SSN: _____

I understand in the event of my death, the distribution of any amount payable from the IUOE Local 132 Health and Welfare Fund will be made to the beneficiary(ies) designated below in accordance with the provisions of the Plan.

To make a beneficiary designation for your Life Insurance and AD&D Insurance, please complete the form below. Please be sure to include all of the requested information for each beneficiary. If you designate more than one beneficiary, the funds will be divided equally among all named beneficiaries unless you specify otherwise or required by law.

IMPORTANT: If you name a minor child as your beneficiary, you must appoint a legal guardian.

Primary Beneficiary(ies)

_____ % _____ _____ _____ _____
Name Relationship Date of Birth Social Security #

_____
Address

_____ % _____ _____ _____ _____
Name Relationship Date of Birth Social Security #

_____
Address

Contingent Beneficiary(ies)

If there is no primary beneficiary(ies) living at the time of my death, I hereby designate the following contingent beneficiary(ies).

_____ % _____ _____ _____ _____
Name Relationship Date of Birth Social Security #

_____
Address

_____ % _____ _____ _____ _____
Name Relationship Date of Birth Social Security #

_____
Address

Signature

I understand this designation supersedes any previous designation and is not valid unless signed and dated.

➔ _____ ➔ _____
Participant's Signature Date

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PENSION FUND

Rejection of the Qualified Survivor Benefit

Only complete this form if you wish to waive your right to a Qualified Survivor Benefit

Upon becoming a Participant in the IUOE Local 132 Pension Fund, should your death occur prior to becoming vested for a retirement benefit, your spouse or designated beneficiary may be entitled to a lump sum death benefit. When you become vested in a future retirement benefit and should you die before your Early Retirement date, your surviving spouse will automatically be entitled to a Qualified Survivor Benefit. This benefit will be in the form of a monthly payment equal to 100% of your earned monthly benefit at the date of your death (known as the 100% Qualified Joint & Survivor Benefit Option).

Your spouse's right to a future Qualified Survivor Benefit can be waived only by you in writing with the written consent of your spouse. Such consent must be upon this form provided by the Fund Office and must be filed with the Fund Office prior to your death. Your spouse cannot waive the Qualified Pre-Retirement Survivor benefit after your death.

Do not complete this form if you wish for your spouse to be entitled to the Qualified Survivor monthly benefit.

Participant's Consent

I hereby reject any Qualified Survivor Benefit which may be payable to my spouse in the event of my death prior to my early retirement date. I understand this rejection will permit the Plan to pay a Lump Sum Death Benefit in lieu of a monthly survivor benefit.

➔ _____ _____ ➔ _____

Participant's Signature (Witnessed by a Notary Public) ID Number or SSN Date

Spouse's Consent

I hereby consent to the Participant's rejection of the Qualified Survivor Benefit which may be payable to me in the event of my spouse's death. I understand this rejection will preclude my receiving a monthly survivor benefit and I may only be entitled to a lump sum death benefit.

➔ _____ _____ ➔ _____

Spouse's Signature (Witnessed by a Notary Public) Social Security Number Date

STATE OF _____

COUNTY OF _____, TO WIT:

The foregoing was acknowledged and completed before me, this the _____ day of _____ , _____ by _____ and _____ , whose names are signed in writing above.

_____ _____

My commission expires Signature of Notary Public

{Notary Seal}

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PENSION FUND

Beneficiary Designation Form

Participant Information

Name: _____ ID Number or SSN: _____

I understand in the event of my death, the distribution of any amount payable from the IUOE Local 132 Pension Fund will be made to the beneficiary(ies) designated below in accordance with the provisions of the Plan.

To make a beneficiary designation for your Pension benefits, please complete the form below. Please be sure to include all of the requested information for each beneficiary. If you designate more than one beneficiary, the funds will be divided equally among all named beneficiaries unless you specify otherwise or required by law.

IMPORTANT: If you name a minor child as your beneficiary, you must appoint a legal guardian.

Primary Beneficiary(ies)

_____ % _____ _____ _____ _____
Name Relationship Date of Birth Social Security #

_____
Address

_____ % _____ _____ _____ _____
Name Relationship Date of Birth Social Security #

_____
Address

Contingent Beneficiary(ies)

If there is no primary beneficiary(ies) living at the time of my death, I hereby designate the following contingent beneficiary(ies).

_____ % _____ _____ _____ _____
Name Relationship Date of Birth Social Security #

_____
Address

_____ % _____ _____ _____ _____
Name Relationship Date of Birth Social Security #

_____
Address

Signature

I understand this designation supersedes any previous designation and is not valid unless signed and dated. I understand if I am married and designate a beneficiary(ies) other than my spouse, then my spouse must consent to such designation by completing the Spousal Consent Form.

→ _____ → _____
Participant's Signature Date

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PENSION FUND

Beneficiary Designation Spousal Consent Form

Participant Information

Name: _____ ID Number or SSN: _____

Only complete this form if the Participant designates a beneficiary other than the Spouse

I, the undersigned spouse of the above name Participant, hereby consent to the designation of the beneficiary(ies) listed by the Participant. I understand the effect of this designation is to designate some or all of my spouse's death benefit to be paid to a beneficiary other than myself.

I understand this designation is not valid unless I consent to it and that my consent is irrevocable unless my spouse revokes the beneficiary designation(s). I further realize I do not have to sign this agreement, but am doing so voluntarily.

I understand that this beneficiary designation and spousal consent is valid only for any benefits paid prior to the Participant's commencement of retirement benefits through International Union of Operating Engineers Local 132 Pension Fund.

I understand that if I do not sign this Spousal Consent Form, I am designated as the beneficiary for any benefits payable through the International Union of Operating Engineers Local 132 Pension Fund.

➔ _____ ➔ _____

Spouse's Signature Date Signed

STATE OF _____

COUNTY OF _____, TO WIT:

The foregoing was acknowledged and completed before me, this the _____ day of _____ , _____ by _____ , who proved to me on the basis of satisfactory evidence to be the person who appeared before me, who affirmed that such consent represents his/her free and voluntary act.

_____ _____

My commission expires Signature of Notary Public

{Notary Seal}

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ANNUITY & SAVINGS FUND

Beneficiary Designation Form

Participant Information

Name: _____ ID Number or SSN: _____

I understand in the event of my death, the distribution of any amount payable from the IUOE Local 132 Annuity & Savings Fund will be made to the beneficiary(ies) designated below in accordance with the provisions of the Plan.

To make a beneficiary designation for your Annuity & Savings benefits, please complete the form below. Please be sure to include all of the requested information for each beneficiary. If you designate more than one beneficiary, the funds will be divided equally among all named beneficiaries unless you specify otherwise or required by law.

IMPORTANT: If you name a minor child as your beneficiary, you must appoint a legal guardian.

Primary Beneficiary(ies)

_____ % _____ _____ _____ _____
Name Relationship Date of Birth Social Security #

_____
Address

_____ % _____ _____ _____ _____
Name Relationship Date of Birth Social Security #

_____
Address

Contingent Beneficiary(ies)

If there is no primary beneficiary(ies) living at the time of my death, I hereby designate the following contingent beneficiary(ies).

_____ % _____ _____ _____ _____
Name Relationship Date of Birth Social Security #

_____
Address

_____ % _____ _____ _____ _____
Name Relationship Date of Birth Social Security #

_____
Address

Signature

I understand this designation supersedes any previous designation and is not valid unless signed and dated. I understand if I am married and designate a beneficiary(ies) other than my spouse, then my spouse must consent to such designation by completing the Spousal Consent Form.

→ _____ → _____
Participant's Signature Date

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ANNUITY & SAVINGS FUND

Beneficiary Designation Spousal Consent Form

Participant Information

Name: _____ ID Number or SSN: _____

Only complete this form if the Participant designates a beneficiary other than the Spouse

I, the undersigned spouse of the above name Participant, hereby consent to the designation of the beneficiary(ies) listed by the Participant. I understand the effect of this designation is to designate some or all of my spouse's death benefit to be paid to a beneficiary other than myself.

I understand this designation is not valid unless I consent to it and that my consent is irrevocable unless my spouse revokes the beneficiary designation(s). I further realize I do not have to sign this agreement, but am doing so voluntarily.

I understand that if I do not sign this Spousal Consent Form, I am designated as the beneficiary for any benefits payable through the International Union of Operating Engineers Local 132 Annuity & Savings Fund.

I hereby voluntarily consent to the above beneficiary designation and understand its effect. I understand that I may be waiving my right to receive a survivor annuity which would otherwise be payable to me.

➔ _____ ➔ _____

Spouse's Signature Date Signed

STATE OF _____

COUNTY OF _____, TO WIT:

The foregoing was acknowledged and completed before me, this the _____ day of _____ , _____ by _____ , who proved to me on the basis of satisfactory evidence to be the person who appeared before me, who affirmed that such consent represents his/her free and voluntary act.

_____ _____

My commission expires Signature of Notary Public

{Notary Seal}