

**PIPE INDUSTRY HEALTH & WELFARE  
FUND OF COLORADO**

**P.O. Box 21240**

**Denver, Colorado 80221**

**Telephone (303) 745-1596 ♦ 1-800-257-2168**

**FAX: (303) 429-1359**

**ENROLLMENT FORM**



**MEMBER INFORMATION (Please Print All Information)**

Last Name		First Name in Full			Middle Name in Full	
Home Address		City			State	Zip
Social Security No.	Telephone No.	Local Union Number	Date of Birth			Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Common Law* <input type="checkbox"/> *Provide appropriate affidavit
			Month	Day	Year	

**DEPENDENT INFORMATION**

Eligible Dependents include your lawful spouse and children up to age 26.

Last Name	First Name	Middle Initial	Social Security #	Birthdate			Relationship	Is Other Health Coverage Available?
				Mo	Day	Year		
Spouse								Yes <input type="checkbox"/> No <input type="checkbox"/>
Children								Yes <input type="checkbox"/> No <input type="checkbox"/>
								Yes <input type="checkbox"/> No <input type="checkbox"/>
								Yes <input type="checkbox"/> No <input type="checkbox"/>
								Yes <input type="checkbox"/> No <input type="checkbox"/>

If yes, complete Other Coverage section below.

**OTHER COVERAGE INFORMATION**

Last Name	First Name	Employer Name	Did this person elect the other coverage?	If yes, Carrier Name & Policy #	Carrier Telephone #

**BENEFICIARY INFORMATION (Death Benefits)**

Name of Beneficiary (Example: May Ann Doe <i>not</i> Mrs. John Doe)	Address of Beneficiary	Relationship	Type or Percentage*

Check here if this is a change in previously designated beneficiaries

*\*If more than one beneficiary is listed, designate as "Primary" or "Contingent" beneficiaries or indicate the percentage that each shall receive (must total 100%).*

I certify that any and all information supplied on this Benefit Enrollment Form is true, complete and accurate, including all other health coverage available to my spouse and other dependents. I also understand that the coverage provided by the Pipe Industry Health & Welfare Fund of Colorado (the "Fund") can be rescinded for misrepresented information or fraud. I further consent and permit the information contained herein to be used by any and all representatives of the Fund for the purpose of providing health coverage to myself and my dependents.

Signed \_\_\_\_\_

Date \_\_\_\_\_