PIPE INDUSTRY HEALTH AND WELFARE FUND OF COLORADO
ENROLLMENT FORM - BASIC PLAN

INSTRUCTIONS: Please provide all information indicated and sign the form. **Complete this form in its entirety, listing all eligible dependents (spouse and/or children) and current beneficiary. This form will replace any other enrollment/beneficiary designation form on file with the Administration Office.** It is necessary to provide copies of documentation such as a marriage certificate, birth certificate, adoption decree, and/or parenting plan if applicable. If removing a spouse, provide a copy of the divorce decree or decree of legal separation. **NOTE:** additional documents may be requested by the Administration Office. **Due to ACA/IRS reporting requirements, you must provide your and your dependent's Social Security Numbers, if you do not provide, this form will be returned to you.**

PLEASE PRINT

□ New Employee □ Beneficiary Change □ Address Change □ Name Change _____
□ Add Dependent(s) □ Remove Dependent(s) (PREVIOUS NAME)

Employer	**Date of Hire**	**Local**

EMPLOYEE INFORMATION

Name (LAST, FIRST, MI)	**SSN**	**Sex** (M/F)	**Birth Date** (MO/DAY/YR)

Mailing Address (STREET, CITY, STATE, ZIP CODE)

Home Phone Number	**Cell Phone Number**	**E-mail Address**

Marital Status □ Single □ Married □ Divorced □ Widowed	**Date of Marriage or Divorce** (MO/DAY/YEAR)

DEPENDENT(S) INFORMATION: list only the eligible dependents you wish to cover (see below for definition)

Name (LAST, FIRST, MI)	**Relationship to Employee**	**Social Security Number**	**Sex** (M/F)	**Birth Date** (MO/DAY/YR)
SPOUSE			□ Male □ Female	
			□ Male □ Female	
			□ Male □ Female	
			□ Male □ Female	

OTHER INSURANCE COVERAGE

Are you, your spouse and/or dependents covered by any other medical, dental or vision plan, including Medicare or Medicaid? □ Yes □ No
If "Yes," please provide the information requested below. If you are eligible for Medicare a copy of your Medicare card must be on file.

Name of Person with Other Coverage SS# or ID# Policy or Group No. Group Phone No.

Name and Address of Other Insurance Company City State Zip

Other insurance covers: □ Employee □ Spouse □ Children Other insurance includes: □ Medical □ Dental □ Vision

I hereby certify that the above information is true, correct and complete to the best of my knowledge and supersedes any beneficiary designation signed prior to the date shown below.

Employee Signature ***(must be signed by participating employee)*** Date

RETURN COPY TO: ADMINISTRATION OFFICE • 1391 SPEER BLVD SUITE 450 DENVER, CO 80204
OR SCAN AND E-MAIL TO: INFO@COPIPEFUNDS.COM • OR FAX TO: 833-263-8956

NOTICE: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

DEFINITION OF ELIGIBLE DEPENDENT

- The Eligible Employee's lawful Spouse
- The Eligible Employee's common-law Spouse as defined under Colorado law
- The Eligible Employee's children, regardless of whether they are married, who are under the age of 26. "Children" are natural children, adopted children, or children for whom the Employee is required to cover by the terms of a Qualified Medical Child Support Order. Stepchildren and foster children are not considered eligible dependents.