Pipe Industry Health and Welfare Fund of Colorado

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PIPE INDUSTRY ADMINISTRATION COMPANY, LLC

Administered by Pipe Industry Administration Company, LLC

ENROLLMENT FORM - BASIC PLAN

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. ***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.***

☐ New Employee ☐ Beneficiary Change ☐ Address Change ☐ Add Dependent(s) ☐ Remove Dependent(s)

☐ Name Change *(Previous Name)* _____

Employee Information

Name: _____ SSN: _____ Sex: _____ Birth Date _____
(Last, First, Middle) *(M/F)* *(MM/DD/YYYY)*

Address: _____
(Street, City, State, ZIP)

Cell Phone: _____ E-mail: _____

Employer: _____ Date of Hire: _____ Local: _____

Dependent(s) Information

List only the eligible dependents you wish to cover. Eligible Dependents are defined as:

- *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.*

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Date of Marriage or Divorce _____
(MM/DD/YYYY)

NAME *(Last, First, Middle)*	**RELATIONSHIP TO EMPLOYEE**	**SSN**	**SEX** *(M/F)*	**BIRTHDATE** *(MM/DD/YYYY)*
	Spouse			

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.

ENROLLMENT FORM - BASIC PLAN *(Continued)*

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 *(Street, 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 enrollment form signed prior to the date shown below.

Signature of Employee: _____ Date: _____
(Must be signed by participating employee)

***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.*

PLEASE RETURN COMPLETED FORM TO:
Pipe Industry Health and Welfare Fund of Colorado
info@copipefunds.com • Fax: (833) 263-8956