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

Last Name	First Name in Full	Middle Name in Full	
Street Address Residence of Beneficiary:	City	State	Zip

Social Security No.	Telephone No.	Local Union No.	Date of Birth Month	Day	Year	Married ☐ Divorced ☐ Widowed ☐ Single ☐ Common Law* ☐ **Provide appropriate affidavit*

Name of Beneficiary (Example: Mary Ann Doe *not* Mrs. John Doe)	Relationship
Address of Beneficiary	
Additional Beneficiary / Address	Relationship

Eligible Dependents include your lawful spouse and your unmarried children dependent on you for financial support and maintenance to age 19, or age 23 if a full-time student. Proof of dependency may be required*. If married, give date: _____

☐ Check here if this is a change in previously designated beneficiary | ***If more than one beneficiary is named, the beneficiaries shall share equally unless otherwise designated.***

LIST YOUR ELIGIBLE SPOUSE & DEPENDENT CHILDREN TO BE COVERED. *PLEASE PRINT**

Last Name	First Name	Middle Initial	Social Security # Required	Birthdate Mo	Day	Year	Relationship
Spouse							
Children							

**It is a Federal requirement that this plan obtain the names and Social Security numbers of all covered individuals (members and all dependents). Please be certain to complete this section of your enrollment card.*

I hereby certify that the information given is true, correct and complete to the best of my knowledge.

Signed_____ Date_____