

ENROLLMENT FORM

**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



MEMBER INFORMATION (Please Print All Information)

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

BENEFICIARY INFORMATION (Death Benefits)

Name of Beneficiary (Example: Mary Ann Doe not 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%).*

DEPENDENT INFORMATION

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: _____

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

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

Signed _____ Date _____