ARIZONA PIPE TRADES

ADMINISTRATIVE OFFICES

HEALTH & WELFARE, PENSION AND DEFINED CONTRIBUTION
3109 N. 24th Street, Suite 105 ♦ Phoenix, AZ 85016
Office: 602.956.1950 ♦ Toll-Free: 877.429.7473 ♦ Fax: 602.956.3016
www.azpipe.org

ENROLLMENT FORM

CHECK ALL THAT APPLY: ☐ **New Enrollment** ☐ **Adding Dependents** ☐ **Dropping Dependents** ☐ **Address Change**

EMPLOYEE'S FULL LEGAL NAME: _____ SSN: _____

LOCAL UNION NO. _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ GENDER: (Circle One) Male Female

DATE OF BIRTH: _____ PHONE NUMBER: (_____) _____ EMAIL: _____

MARITAL STATUS: ☐ Married (Date of Marriage) _____ ☐ Single ☐ Divorced (Date of Divorce) _____

MEDICAL/Rx PLAN: (Provided by)	**DENTAL PLAN: (Provided by)**	**VISION PLAN: (Provided by)**
▪ **Cigna OAP (Trust Self-Funded Plan)** ▪ **Prescriptions – Cigna**	☐ **Delta Dental PPO – Group#4287**	▪ **Trust Self-Funded**

NOTE: IF YOU, YOUR SPOUSE OR ANY OF YOUR DEPENDENTS ARE ON MEDICARE, PLEASE INCLUDE A COPY OF YOUR MEDICARE CARD.

DEPENDENTS - (Including Spouse)
YOU MUST ATTACH LEGAL DOCUMENTATION THAT APPLIES TO ADD YOUR DEPENDENTS:
Birth Certificate(s) for children, Marriage Certificate for spouse, Legal Adoption papers, Legal Guardianship papers

FULL NAME	RELATIONSHIP	DATE OF BIRTH	SSN	GENDER

I agree to notify the Fund Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that stating false or misleading information or the omission of material information could be grounds for denial of benefits. I also understand that the coverage provided by the Arizona Pipe Trades Benefit Funds (the "Fund") can be rescinded for misrepresented information or fraud. I further consent and permit the information contained to be used by any and all representatives of the Fund for the purpose of proving health coverage to myself and my dependents.

MEMBER SIGNATURE _____ **DATE:** _____

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