INTERMOUNTAIN IRONWORKER'S TRUST FUNDS

ENROLLMENT FORM (ACTIVE PLAN)

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

EMPLOYEE'S FULL LEGAL NAME: _____ SSN: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ DATE OF BIRTH: _____ GENDER: (Mark One) Male ____ Female ____

PHONE NUMBER: (_____) _____ EMAIL: _____

EMPLOYER: _____ DATE OF HIRE: _____ LOCAL UNION # _____

MEDICAL PLAN (Provided By):	**PRESCRIPTION (Provided By):**	**LIFE INSURANCE (Provided By):**
CIGNA	**SAV-RX**	**SELF FUNDED**
DENTALPLAN (Provided By):		**VISION (Provided By):**
CIGNA		**SELF FUNDED**

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

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.

MEMBER SIGNATURE: _____ DATE: _____

Mailing Address: P.O. Box 30580, Salt Lake City, UT 84130-0580
5295 S. Commerce Dr. ♦ Suite #220 (Bridge Building) ♦ Murray, UT 84107
Phone: 801-904-4897 ♦ Toll Free: 888-867-9510
www.iiwbenefits.org

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