EMPLOYEE PAINTERS' TRUST

ENROLLMENT FORM

CHECK ALL THAT APPLY:

☐ **New Enrollment** ☐ **Add Dependent** ☐ **Remove Dependent** ☐ **Plan Change** ☐ **Address Change**

EMPLOYEE'S FULL LEGAL NAME:_____

SSN:_____ DATE OF BIRTH:_____ GENDER: _____

ADDRESS:_____ APT/SUITE:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE NUMBER: (_____)_____ EMAIL: _____

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

EMPLOYER_____ DATE OF HIRE:_____LOCAL UNION #: _____

MEDICAL PLAN: (Provided By)	**DENTAL PLAN: (Provided By)**	**VISION PLAN: (Provided By)**
AETNA	CAREINGTON DENTAL **	VISION SERVICE PLAN (VSP)**
**** Dental and Vision benefits excluded from Material Handlers and Residential Painting benefits**		

NOTE: IF YOU ARE ADDING ANY DEPENDENTS WHO ARE ON MEDICARE, PLEASE INCLUDE A COPY OF THEIR 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	SSN	GENDER	DATE OF BIRTH	RELATIONSHIP

I agree to notify the Trust 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 it is a crime to knowingly provide false, incomplete, or misleading information for the purpose of defrauding obtaining plan coverage. Penalties may include imprisonment, fines, and denial of benefits.

EMPLOYEE SIGNATURE_____**DATE** _____

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