



# Utah Pipe Trades Trust Funds

## Pension Health and Welfare

## ENROLLMENT FORM

Date of Hire: \_\_\_\_\_  
Event Date: \_\_\_\_\_  
Effective Date: \_\_\_\_\_

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: (Circle One) Male Female

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

<b><u>MEDICAL PLAN</u></b> (New Providers):  Cigna Express Scripts (RX)	<b><u>DENTAL &amp; VISION PLANS:</u></b>  **Dental and Vision Coverage is provided only for a temporary basis through December 31, 2026. It is a reimbursement benefit only.**
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**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 LEGAL NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	RELATIONSHIP

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: