



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

PHONE NUMBER: (____) _____ EMAIL: _____

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

MEDICAL PLAN (New Providers):

Cigna
Express Scripts (RX)

DENTAL & VISION PLANS:

****Dental and Vision Coverage is provided only for a temporary basis through December 31, 2026. It is a reimbursement benefit only.****

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:** _____

◆◆◆Physical Address: 7180 Koll Center Parkway, Suite 200 Pleasanton, CA 94566 ◆◆◆Mailing Address: P.O. Box 1975, San Ramon, California 94583

◆◆◆Phone 925.398.7041 ◆◆◆Toll Free 877.416.8181 ◆◆◆Facsimile 925.462.0108

◆◆◆www.utpipetradesbenefits.org ◆◆◆staff@utpipetradesbenefits.org