



# 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: \_\_\_\_\_

<p><b><u>MEDICAL PLAN (New Providers):</u></b></p> <p>Cigna Express Scripts (RX)</p>	<p><b><u>DENTAL &amp; VISION PLANS:</u></b></p> <p><b>**Dental and Vision Coverage is not provided**</b></p>
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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:** \_\_\_\_\_