Pipe Industry Health and Welfare Fund of Colorado

ENROLLMENT/BENEFICIARY DESIGNATION FORM

INSTRUCTIONS: Provide all information indicated and sign the form. **Complete this form in its entirety, listing all eligible dependents (spouse and/or children) and current beneficiary. This form will replace any other enrollment/beneficiary designation form on file with the Administration Office.** It is necessary to provide copies of documentation such as a marriage certificate, birth certificate, adoption decree, and/or parenting plan if applicable. If removing a spouse, provide a copy of the divorce decree or decree of legal separation. **NOTE:** Additional documents may be requested by the Administration Office. **Due to ACA/IRS reporting requirements, you must provide your and your dependent's Social Security Numbers, if you do not provide, this form will be returned to you.**

PLEASE PRINT

□ New Employee □ Beneficiary Change □ Address Change □ Name Change ________________________
□ Add Dependent(s) □ Remove Dependent(s) (PREVIOUS NAME)

Employer	Date of Hire	Local

EMPLOYEE INFORMATION

Name (LAST, FIRST, MI)	Social Security Number	Sex (M/F)	Birth Date (MO/DAY/YR)

Mailing Address (STREET, CITY, STATE, ZIP CODE)

Home Phone Number	Cell Phone Number	E-mail Address

Marital Status	Date of Marriage or Divorce (MO/DAY/YEAR)
□ Single □ Married □ Divorced □ Widowed	

DEPENDENT(S) INFORMATION: List only the eligible dependents you wish to cover (see definition below)

Name (LAST, FIRST, MI)	Relationship to Employee	Social Security Number	Sex (M/F)	Birth Date (MO/DAY/YR)
			□ Male □ Female	
			□ Male □ Female	
			□ Male □ Female	
			□ Male □ Female	

BENEFICIARY DESIGNATION FOR DEATH BENEFITS – ACTIVE PLAN (Effective upon receipt by the Administration Office)

Please designate a beneficiary to whom death benefits will be paid.

Primary Beneficiary ____ Relationship ___________________________________

Beneficiary Address ____ Beneficiary Social Security # ____________________

I hereby certify that the above information is true, correct and complete to the best of my knowledge and supersedes any beneficiary designation signed prior to the date shown below.

____ ______________________

Employee Signature ***(must be signed by participating employee)*** Date

RETURN WHITE COPY TO: ADMINISTRATION OFFICE • P.O. BOX 34203 • SEATTLE, WA 98124-1203
OR SCAN AND E-MAIL TO: FORMS@WPAS-INC.COM • OR FAX TO: 206-505-9727
RETAIN A COPY FOR YOUR RECORDS

NOTICE: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

DEFINITION OF ELIGIBLE DEPENDENT

- The Eligible Employee's lawful Spouse
- The Eligible Employee's common-law Spouse as defined under Colorado law
- The Eligible Employee's children, regardless of whether they are married, who are under the age of 26. "Children" are natural children, adopted children, or children for whom the Employee is required to cover by the terms of a Qualified Medical Child Support Order. Stepchildren and foster children are not considered eligible dependents.