Connecticut Pipe Trades Health Fund
1155 Silas Deane Highway
Wethersfield, CT 06109-4318
860-571-9191

Local 777

ENROLLMENT, CENSUS AND COVERAGE INFORMATION

TO BE COMPLETED BY THE PARTICIPANT
(Please answer all questions)

1. Your name: *(print)*________________ Phone: (   ) ________
2. Present address: No. ____ Street ________ City________ State ____ Zip Code______

INSTRUCTIONS:
Complete the section providing information for yourself. If you are married, you must complete the section pertaining to your spouse. You must also provide the requested information for each of your dependent children, and sign and date the back of the form. ***Failure to supply all necessary documents listed below and complete all questions will result in delay of claim payment.***

You must return the completed form to the Health Fund Office along with the following documents:

- A copy of your Birth Certificate
- A "Certificate of Group Health Insurance" from your, or any family members, prior Insurance Company
- If Married, a copy of your spouses Birth Certificate & Marriage License
- For each Dependent Child, a copy of the "Certificate of Live Birth", indicating Biological Parents and/or court, state, legal Documents (if applicable)
- Provide other health coverage information if your spouse is also insured
- If Divorced, send Divorce Decree language relating to Health Coverage for all Dependents to be considered for coverage

I PLEASE COMPLETE THIS SECTION PROVIDING INFORMATION ON YOURSELF:

Name: ____________ Soc. Sec. # __________ Date of Birth:________

Street Address: ____________________

City/State: ____________ Zip: ______ Phone:________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Legally Separated ☐ Widowed

II IF MARRIED, PLEASE COMPLETE THE FOLLOWING SECTION:

Spouses Name: ____________ Soc. Sec. #: __________

Date of Birth: ____________ Date of Marriage: __________

Is your spouse employed? ☐ Yes ☐ No

If yes, Name and Address of Employer: ________________

Does spouse have other insurance coverage? ________ Phone: ________

Name of Health Insurance Company, HMO, etc. and effective date: __________

III PLEASE COMPLETE ONE SECTION FOR EACH DEPENDENT CHILD:

1. Dependents Name: ________________ Date of Birth: ______ Sex: M / F
Last *First* *Middle Init.*
Is this dependent your ☐ Natural Child? ☐ Adopted Child? ☐ Stepchild? Social Security #________
Does the dependent reside with you? ☐ Yes ☐ No
Is other insurance provided for child? ☐ Yes ☐ No Effective date: ________
Full Time Student? ☐ Yes ☐ No

2. Dependents Name: ________________ Date of Birth: ______ Sex: M / F
Last *First* *Middle Init.*
Is this dependent your ☐ Natural Child? ☐ Adopted Child? ☐ Stepchild? Social Security #________
Does the dependent reside with you? ☐ Yes ☐ No
Is other insurance provided for child? ☐ Yes ☐ No Effective date: ________
Full Time Student? ☐ Yes ☐ No

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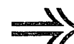

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3. Dependents Name: ______________________________ Date of Birth: __________ Sex: M / F
Last *First* *Middle Init.*
Is this dependent your ☐ Natural Child? ☐ Adopted Child? ☐ Stepchild? Social Security # ______________
Does the dependent reside with you? ☐ Yes ☐ No
Is other insurance provided for child? ☐ Yes ☐ No Effective date: ______________
Full Time Student? ☐ Yes ☐ No

4. Dependents Name: ______________________________ Date of Birth: __________ Sex: M / F
Last *First* *Middle Init.*
Is this dependent your ☐ Natural Child? ☐ Adopted Child? ☐ Stepchild? Social Security # ______________
Does the dependent reside with you? ☐ Yes ☐ No
Is other insurance provided for child? ☐ Yes ☐ No Effective date: ______________
Full Time Student? ☐ Yes ☐ No

5. Dependents Name: ______________________________ Date of Birth: __________ Sex: M / F
Last *First* *Middle Init.*
Is this dependent your ☐ Natural Child? ☐ Adopted Child? ☐ Stepchild? Social Security # ______________
Does the dependent reside with you? ☐ Yes ☐ No
Is other insurance provided for child? ☐ Yes ☐ No Effective date: ______________
Full Time Student? ☐ Yes ☐ No

6. Dependents Name: ______________________________ Date of Birth: __________ Sex: M / F
Last *First* *Middle Init.*
Is this dependent your ☐ Natural Child? ☐ Adopted Child? ☐ Stepchild? Social Security # ______________
Does the dependent reside with you? ☐ Yes ☐ No
Is other insurance provided for child? ☐ Yes ☐ No Effective date: ______________
Full Time Student? ☐ Yes ☐ No

IV I hereby confirm that the information provided is accurate and complete. I understand that the information provided will be relied upon in determining eligibility for benefits and/or processing claims.

Participant Signature ______________________________ **Date** ______________