Colorado Finishing Trades
Health and Welfare Fund
2821 South Parker Road
Suite 215
Aurora, Colorado 80014
Phone: (303)745-1941

ANNUAL INSURANCE FORM

NAME OF EMPLOYEE ____

HOME ADDRESS ____
STREET APT. NO CITY STATE ZIP

HOME PHONE NUMBER ____

PERSONAL DATA

DATE OF BIRTH ____________________ SOCIAL SECURITY NUMBER ____________________

GENDER ☐ MALE ☐ FEMALE **MARITAL STATUS** ☐ MARRIED ☐ SINGLE ☐ OTHER

SPOUSE INFORMATION

NAME OF SPOUSE ______________________________ DATE OF BIRTH ____________________

RELATION ☐ WIFE ☐ HUSBAND ☐ COMMON LAW

EMPLOYED ☐ YES ☐NO REQUESTING COVERAGE WITH THIS PLAN? ____________________

SPOUSE EMPLOYER NAME AND ADDRESS

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DEPENDENT INFORMATION (List **all** dependents that you want on your health and dental plan)

NAME	DATE OF BIRTH	SOCIAL SECURTIY #	M	F	RELATION
SPOUSE:					
CHILD:					
CHILD:					
CHILD:					
CHILD:					

Are you or any of your dependents insured under any other group insurance or government plan which will also pay medical expenses? ☐ **No** ☐ **Yes** If yes, please explain ______________________________

I/We jointly certify that the above information is true and correct I/we hereby authorize all doctors, hospitals, pharmacists or other institutions rendering care and treatment to furnish the Group Employee Health Plan full information regarding treatment rendered (including copies of their records). I/we also authorize any Union Trust Fund Employer or Insurance Carrier to furnish the Group Employee Health Plan information regarding benefits to which I/we may be entitled. A Photostat copy of this authorization shall be considered as effective and valid as the original.

______________________________ ______________________________
SIGNATURE OF EMPLOYEE AND DATE SIGNATURE OF SPOUSE AND DATE