Colorado Finishing Trades Health and Welfare Fund

2821 South Parker Road
Suite 215
Aurora, Colorado 80014
Phone: (303)745-1941

ENROLLMENT FORM

NAME OF EMPLOYEE _____

HOME ADDRESS _____
STREET APT NO. CITY STATE ZIP

HOME PHONE_____ CELL PHONE_____

PERSONAL DATA

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER_____

GENDER ☐MALE ☐FEMALE MARITAL STATUS ☐MARRIED ☐SINGLE ☐COMMON LAW

BENEFICIARY NAME _____
RELATIONSHIP

BENEFICIARY ADDRESS _____
STREET APT NO. CITY STATE ZIP

SPOUSE INFORMATION

NAME OF SPOUSE_____ RELATION ☐WIFE ☐HUSBAND ☐COMMON LAW
SOCIAL SECURITY #_____ REQUESTING COVERAGE WITH THIS PLAN? ☐YES ☐NO
DATE OF BIRTH_____ EMPLOYED? ☐ YES ☐NO

NAME AND ADDRESS OF EMPLOYER

_____

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

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	M	F	RELATION

NOTE: IF YOU ARE REQUESTING COVERAGE FOR YOUR SPOUSE WE DO REQUIRE A COPY OF YOUR MARRIAGE CERTIFICATE
IF YOU ARE REQUESTING COVERAGE FOR DEPENDENT CHILDREN WE DO REQUIRE A COPY OF THEIR BIRITH CERTIFICATES AND A COPY OF ANY DIVORCE DECREES.

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

Proceed to other side

Additional Beneficiary

BENEFICIARY NAME _____
RELATIONSHIP

BENEFICIARY ADDRESS _____
STREET APT NO. CITY STATE ZIP

BENEFICIARY NAME _____
RELATIONSHIP

BENEFICIARY ADDRESS _____
STREET APT NO. CITY STATE ZIP

Benefits are provided under the Colorado Finishing Trades Health and Welfare Fund. Plan Participant rights under ERISA Section 502 (a) are fully explained in the Summary Plan Description Booklet provided upon meeting the eligibility requirements of the Plan. Life insurance coverage is Underwritten by ReliaStar Life Insurance Company.

Fraud Statement

All claim or enrollment forms submitted to the Plan shall be honest, accurate and as complete as possible. If the Board of Trustees finds, at any time, that there has been an intentional falsification of any enrollment form or document submitted in support of a claim, either by use of forgery or intentionally inaccurate or misleading information or any other fraudulent means whatsoever, it shall have the right to immediately terminate coverage and/or refuse to honor any claim which is related to the falsified or fraudulent information. The coverage to be terminated, if the Board of Trustees so determines, shall be that of the Eligible Employee and Dependents who are related to the person submitting the false or fraudulent claim.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.