ENROLLMENT FORM

SECTION 1 – Must be Completed in Full (Members Information Only in Section 1)

MAIL TO:
East Central Illinois Pipe Trades
H & W Fund
c/o HealthSCOPE Benefits
P.O. Box 68994
Indianapolis, Indiana 46268

Last Name	First Name in Full	Middle Name in Full

Date of Birth (Month, Day, Year)	Current Local Union No.	Sex	Social Security Number
		Male ☐ Female ☐	☐☐☐-☐☐-☐☐☐☐

Home Address	City State Zip + 4	Telephone Number
	☐☐☐☐☐-☐☐☐☐	( )

Email Address

SECTION 2 – Must be Completed for Welfare Coverage

Check One ➔	Single ☐	Married ☐ Remarried ☐ Date of Marriage _____	Widow ☐ Widower ☐	Separated ☐	Divorced ☐ Date of Divorce _____

PRINT THE NAMES OF ALL ELIGIBLE DEPENDENTS BELOW YOU WISH TO ENROLL

A copy of your marriage license, birth certificates, adoption papers, support orders must be attached for all dependents listed below. In the event of enrolling a stepchild, the divorce decree of the natural parents must be attached.

	Birth Date			Relationship (Check one)				
	Month	Day	Year	Legal Spouse	Son	Daug.	STEPCHILD Son	STEPCHILD Daug.
Full Name Social Security Number ☐☐☐-☐☐-☐☐☐☐								
Full Name Social Security Number ☐☐☐-☐☐-☐☐☐☐								
Full Name Social Security Number ☐☐☐-☐☐-☐☐☐☐								
Full Name Social Security Number ☐☐☐-☐☐-☐☐☐☐								
Full Name Social Security Number ☐☐☐-☐☐-☐☐☐☐								
Full Name Social Security Number ☐☐☐-☐☐-☐☐☐☐								

If you have additional dependents, please list on the back.

SECTION 3 – Named Beneficiary(ies) – Life Insurance

Last Name	First Name in Full	Middle Name in Full	Social Security Number
			☐☐☐-☐☐-☐☐☐☐
			☐☐☐-☐☐-☐☐☐☐

I certify that all information is correct and understand it is a crime to complete form with information which I know is false.

PARTICIPANT SIGNATURE: X _____ DATE: _____