CONTRACTORS HEALTH TRUST

ENROLLMENT FORM

2380 S TEJON STREET ✦ ENGLEWOOD, CO 80110 ✦ 303-935-2475

☐ Monthly Contribution Method
☐ Hour Bank Method
☐ Plan Option Selected _____
☐ Delta Dental ☐ Alpha Dental

Please Print All Answers				Effective Date _____
Name of Employee (Last, First, Middle Initial)	Phone Number	Male ☐ Female ☐	Date Birth _____/_____/_____	Social Security Number
Mailing Address (Street or PO, City, State, Zip)		Employee Email Address		☐ Licensed Married ☐ Common Law Married ☐ Single ☐ Divorced ☐ Widowed
Employer	Date Employed	Job Title	☐ Field Employee ☐ Office Employee	

LIST YOUR ELIGIBLE DEPENDENTS TO BE COVERED. THESE INCLUDE YOUR LAWFUL SPOUSE AND YOUR CHILDREN UP TO AGE 26.

Last Name	First Name	Middle Initial	Social Security # *Required	Relationship	Birthdate Month/ Day /Year	M-Male F-Female
Spouse					/ /	
Spouse Email				Spouse Phone Number		
Children					/ /	
					/ /	
					/ /	
					/ /	
					/ /	

*It is a Federal requirement that this plan obtain the names and Social Security numbers of all covered individuals (members and dependents). Please be sure to complete this section of your enrollment form.

Other Coverage - Please list any other insurance or government plan coverage for you and your dependent(s).

Last Name	First Name	Employer Name	Carrier	Policy #	Carrier Telephone #

BENEFICIARY INFORMATION For Life Benefit included with Medical coverage

Name of Beneficiary (Example: Mary Ann Jones *not* Mrs. John Jones)	Address	Relationship
Additional Beneficiary	Address	

If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries (or beneficiary) as survive the insured, unless otherwise provided herein. If no designated beneficiary survives, settlement will be made to the estate of the insured unless otherwise provided in the Group policy.

I HEREBY CERTIFY THE ABOVE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I AUTHORIZE THE RELEASE OF ANY FACTS CONCERNING THE INJURY, ILLNESS, OR TREATMENT OF MYSELF OR MY DEPENDENTS. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

▸ _____ _____ ▸ _____

EMPLOYEE'S SIGNATURE DATE SIGNED DEPENDENT-POLICYHOLDER (IF OTHER INSURANCE INDICATED)