CONTRACTORS HEALTH TRUST

ENROLLMENT FORM

CONTRACTORS HEALTH TRUST

P.O. Box 21240 ✦ Denver, CO 80221 ✦ 303.428.5586 ✦ 1.888.221.2201

☐ Monthly Contribution Method
☐ Hour Bank Method
☐ Plan Option Selected _____

Please Print All Answers | ADMINISTRATIVE USE ONLY | Life Amount $_____ | Effective Date _____

Name of Employee (Last, First, Middle Initial)	Phone Number	Male ☐ Female ☐	Date of Birth __/__/__	Social Security Number

Address (Street, 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. THESE INCLUDE YOUR LAWFUL SPOUSE AND YOUR CHILDREN UP TO AGE 26. PLEASE PRINT.

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

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)

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

▶ _____
SIGNED DEPENDENT – POLICYHOLDER (IF OTHER INSURANCE INDICATED)