

Pipe Fitters' Local 597
WELFARE & RETIREMENT FUNDS

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Employer Trustees
 Frederick S. Oyer
 John D. Curran
 Marc A. Pittas
 Stephen L. Lamb

INSURANCE ENROLLMENT FORM

Member's Name _____
 First Middle Initial Last

_____ Social Security Number Local 597 Union Card Number

Address _____
 Street City State Zip Code

_____ Phone Number E-Mail Address

**Complete all sections listed below for your dependents
 include Social Security Numbers**

Print First and Last Name	Birth Date	Sex		Social Security Number
		Male	Female	
<i>Spouse:</i>				
	/ /	<input type="checkbox"/>	<input type="checkbox"/>	
Spouse Employed: Yes <input type="checkbox"/> No <input type="checkbox"/>				
<i>Children:</i>				
	/ /	<input type="checkbox"/>	<input type="checkbox"/>	
	/ /	<input type="checkbox"/>	<input type="checkbox"/>	
	/ /	<input type="checkbox"/>	<input type="checkbox"/>	
	/ /	<input type="checkbox"/>	<input type="checkbox"/>	
	/ /	<input type="checkbox"/>	<input type="checkbox"/>	

The term dependent means any one of the following individuals: An employee's spouse. Each unmarried child of an employee from birth to 18 years of age. Each unmarried child between the ages of 18 and 23 years of age who is enrolled as a full-time student in an accredited school, college or university and who is dependent upon the employee for financial support. Such child is considered a dependent during the school years and the intervening vacations. An unmarried child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap provided: such incapacity began prior to the limiting age of 18 and such child is chiefly dependent upon the employee for financial support and maintenance: and proof of such incapacity is submitted to the Trustees within 31 days of the date such dependents eligibility would otherwise terminate. The Plan may be required to extend coverage to dependents that lose full-time student status and in turn their coverage due to a serious illness or injury. Coverage will be extended for up to one year from date of the medically necessary leave of absence, but may end it earlier if the dependent's coverage terminates for any other reason as set forth in the Plan. The Plan must receive written certification from the dependent's physician that the dependent is suffering from a serious illness or injury and a leave of absence is medically necessary.

**Each Eligible Employee Must File an Enrollment Form
 ***** Form Must Be Signed *******

Member's Signature _____ Date / /