**New Mexico Pipe Trades Health & Welfare Trust Fund**

Administrative Offices

6301 Indian School RD Suite 660 Telephone (505) 881-3141

Albuquerque, New Mexico 87110

**ENROLLMENT FORM – PLEASE PRINT INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Participant Name ( Last, First, Middle Initial) | Date of Birth  MM/DD/YY | Sex  M  F | Married [ ]  Single [ ]  Widowed [ ] | SSN   * - |
| Address (Street, City, State, Zip Code) | | | | Telephone # |
| Spouse Name (Last, First Middle) | Date of Birth  MM/DD/YY | Is Spouse Employed | | SSN   * - |
| Name & Address of Spouse’s Employer | | | | |
| Spouse’s Group Insurance Carrier & Policy Number | | | | |

**List below all children under age 26 – legal proof is required for all Dependents**

|  |  |  |  |
| --- | --- | --- | --- |
| Social Security No. | Last Name, First, Initial | Date of Birth | Relationship |
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| --- |
| Full Name of Beneficiary Relationship |
| Address of Beneficiary (street, city, state, zip code |

I hereby certify that the information provided in this form, to the best of my knowledge and belief, is true, correct and complete. I understand that any false statements in this form may affect my and /or my dependent’s continued eligibility for benefits under the Welfare fund. I further understand that completion of this form does not guarantee eligibility for benefits.

Date Signature