

Ohio Carpenters Health Fund

33 Fitch Blvd
Austintown, Ohio 44515

Telephone: 1-800-435-2388
330-270-0453

Enrollment Form

If this form is to change current information, mark type of change below:

Add dependents _____ Change address _____ Delete Dependents _____

Change Beneficiary _____

Please complete and return this form to assure enrollment or that your changes are processed. If additional documentation or information is needed, you will be notified:

Local Number: _____

Member Name: _____

Social Security: _____

Address: _____

Phone Number: _____

Date of Birth: _____

Sex: _____

Marital Status: _____

Spouse Name: _____

Date of Marriage: _____

Social Security No. _____

Date of Birth: _____

Sex: _____

Dependent Name:

Relationship to Member:

Date of Birth:

Sex:

Social Security:

Dependent Name:

Relationship to Member:

Date of Birth:

Sex:

Social Security:

Dependent Name:

Relationship to Member:

Date of Birth:

Sex:

Social Security:

Dependent Name:

Relationship to Member:

Date of Birth:

Sex:

Social Security:

Are any family members covered by another group health plan? Yes No

DEATH BENEFIT INFORMATION

Name of Beneficiary _____ SSN#: _____

Relationship: _____

Address: _____

Intentionally withholding or falsifying information requested on the form may result in loss of coverage for you and your dependents.

Member Signature: _____ Date: _____