

Mahoning and Trumbull County Building Trades  
Insurance 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: \_\_\_\_\_

**OVER**

**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 \_\_\_\_\_ 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: \_\_\_\_\_