"RETIREE" ENROLLMENT FORM

AFL Hotel & Restaurant Workers Health & Welfare Trust Fund

Retiree Date:_____

Credit Service:_____

Benefit & Risk Management Services
560 N. Nimitz Highway, Suite 209 - Honolulu, HI 96817
Phone: Oahu Administrative Office - (808) 523-0199
Neighbor Islands Toll Free 1 (866) 772-8989; Fax: (808) 537-1074

Part I - THIS SECTION IS FOR **MEMBER** INFORMATION ONLY

Last Name	First Name in Full	Middle Name in Full	☐ Male ☐ Female

Mailing Address	City	State	Zip Code

Social Security Number	☐ Married ☐ Single	THIS SECTION MUST BE COMPLETED	**Check One Dental Plan** ☐ HDS
Date of Birth (mm/dd/yyyy)	Telephone No.		**Medical Plan** ☐ AFL Indemnity Plan ☐ Kaiser

Name of Employer: Date of Hire:

Part II - BENEFICIARY INFORMATION - PLEASE DO NOT LEAVE THIS SECTION BLANK

Name (Last, First, Middle Initial)	Relationship to You	Beneficiary's Social Security No.	Date of Birth (mm/dd/yyyy)

Beneficiary's Mailing Address	City	State	Zip	Beneficiary's Telephone No.

Part III - SPOUSE INFORMATION - SUBMIT COPY OF MARRIAGE CERTIFICATE

Name (Last, First, Middle Initial)	☐ Husband ☐ Wife	Spouse's Social Security No.	Date of Birth (mm/dd/yyyy)

Date of Marriage:

Is your Spouse working? Yes _____ No _____

If Yes, Full Time_____ Part Time _____

Name of Employer: _____

Is your spouse eligible for other medical coverage? Yes _____ No _____

If Yes, list the name of the Medical Insurance Carrier: _____

Medical Insurance Effective Date: _____

If No, please contact the Trust Fund Office for the amount that you will need to pay in order to cover your spouse.

Pursuant to the Rules and Regulations adopted by the Board of Trustees, if your covered spouse and/or any dependent children are working more than 20 hours per week for a four consecutive week period, he/she must obtain medical coverage for themselves through their employer.

If coverage is provided through your dependents employer, you may retain them as dependents covered under your plan subject to all other eligbility requirements at no cost to you and the covered dependents will generally realize full coverage for services covered by both plans.

If medical coverage for your working spouse and/or dependent children is not obtained as stated above, you will be assessed an amount for continuation of coverage for your spouse and each working dependent covered under your plan. Failure to remit the assessed amount on a timely basis will be cause for termination of coverage for each affected dependent.

The undersigned represents that to the best of my knowledge, and after inquiring of my spouse and each dependent, I have read and understand this INFORMATION REQUEST CARD, and declare all information set forth herein to be true, complete and accurate. The undersigned further declares that I understand that falsification of the requested information may result in immediate loss of dependent coverage.

_____

Part IV - DEPENDENT CHILDREN - PLEASE SUBMIT COPY OF BIRTH CERTIFICATE(S)

List names of eligible dependents

Name (Last, First, Middle Initial)	☐ Son ☐ Daughter	Social Security Number	Date of Birth (mm/dd/yyyy)
1)			

Is your dependent working? Yes _____ No _____

If Yes, Full Time _____ Part Time _____

Name of Employer: _____

Is your dependent eligible for other medical coverage? Yes _____ No _____

If Yes, list the name of the Medical Insurance Carrier: _____

Medical Insurance Effective Date: _____

Name (Last, First, Middle Initial)	☐ Son ☐ Daughter	Social Security Number	Date of Birth (mm/dd/yyyy)
2)			

Is your dependent working? Yes _____ No _____

If Yes, Full Time _____ Part Time _____

Name of Employer: _____

Is your dependent eligible for other medical coverage? Yes _____ No _____

If Yes, list the name of the Medical Insurance Carrier: _____

Medical Insurance Effective Date: _____

Name (Last, First, Middle Initial)	☐ Son ☐ Daughter	Social Security Number	Date of Birth (mm/dd/yyyy)
3)			

Is your dependent working? Yes _____ No _____

If Yes, Full Time _____ Part Time _____

Name of Employer: _____

Is your dependent eligible for other medical coverage? Yes _____ No _____

If Yes, list the name of the Medical Insurance Carrier: _____

Medical Insurance Effective Date: _____

Name (Last, First, Middle Initial)	☐ Son ☐ Daughter	Social Security Number	Date of Birth (mm/dd/yyyy)
4)			

Is your dependent working? Yes _____ No _____

If Yes, Full Time _____ Part Time _____

Name of Employer: _____

Is your dependent eligible for other medical coverage? Yes _____ No _____

If Yes, list the name of the Medical Insurance Carrier: _____

Medical Insurance Effective Date: _____

TO BE ENROLLED, YOU MUST SUBMIT VERIFICATION DOCUMENTS FOR SPOUSE AND ALL DEPENDENTS. MARRIAGE CERTIFICATE FOR SPOUSE; BIRTH CERTIFICATE(S) FOR ALL DEPENDENT CHILDREN COVERED UNDER THE PLAN.

Your Signature in Full	Date Signed
X	

Email Address