

ENROLLMENT FORM

Hawaii Teamsters Health & Welfare Trust Fund

Benefit & Risk Management Services

560 N. Nimitz Highway, Suite 209 - Honolulu, HI 96817

Phone: Oahu Administrative Office - (808) 523-0199 Satellite Office: (808) 842-0392

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
Social Security Number	Date of Birth (mm/dd/yyyy)	☐ Married ☐ Single	Telephone Number

Mailing Address

Name of Employer:

Date of Hire:

THIS SECTION MUST
BE COMPLETED

Check One
Dental Plan

☐

HDS

☐

HMSA
("DHMO")

Check One
Medical Plan

☐

UHA 600 (PPO)

☐

Kaiser (HMO)

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 Telephone No.	
Beneficiary's Mailing Address		

Part III - SPOUSE INFORMATION - SUBMIT COPY OF MARRIAGE CERTIFICATE

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

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	Social Security Number
2)			

Is your dependent working? Yes _____ No _____ 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 _____