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	☐	DCCH / Gentle Dental
Check One Medical Plan	☐	UHA 600	☐	Kaiser

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	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