

EC-1
Rev July 2007

**Hawaii Employer-Union Health Benefits Trust Fund
ENROLLMENT FORM FOR ACTIVE EMPLOYEES**

1. Event:
2. Event Date: (MM/DD/YY)
/ /

See Instructions on reverse side BEFORE completing this form. Refer to your benefits guide or our website for plan details.

| | | | | | |
|---|------------|---------------|--|--|--|
| 3a. Employee's Last Name, First, M.I. | | | 3b. Social Security Number (for new enrollees only) or EUTF ID Number: | | |
| 3c. Mailing Address (<input type="checkbox"/> Check this box if your address has changed): | | | 4. If your spouse or Domestic Partner is a State or County Employee or Retiree, please provide their SSN or EUTF ID. | | |
| 3d. City: | 3e. State: | 3f. Zip Code: | If you are including your spouse or domestic partner in your health benefits plans, please complete sections 5 - 9. | | |

| | | | | | | | | | |
|---|--------------------------|--|--|----------------------------|---------------------------|--|--|-------------------------|-----------|
| 3g. Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single | | 3h. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | | 3i. Birth Date: (MM/DD/YY) | | 3j. Phone Number - Work | | 3k. Phone Number - Home | |
| 5a. Add | 5b. Delete | 6a. Dependents: First Name, M.I., Last Name (if different) | | | 6b. Birth Date (MM/DD/YY) | 6c. Social Security Number or EUTF ID Number | | 7. Relationship | 8. Gender |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | M F |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | M F |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | M F |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | M F |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | M F |

9. Plan Selections, Changes or Cancellations - Make your selection by checking the box for the appropriate benefit plans below. Select either Self, 2-Party, Family or Cancel/Waive coverage. Choose only one box in each plan section.

| Plan Section | Carrier Selection | Self | 2-Party | Family | Cancel / Waive |
|---|--|--------------------------|--------------------------|--------------------------|--------------------------|
| Medical Plan Select one plan from this list. Except for RSN Supplemental and EUTF HDHP plans as noted, the Prescription Drug and Chiropractic plan are bundled with the Medical plan. | EUTF PPO Medical (HMA Network, NMHC Drug, RSN ChiroPlan) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | EUTF PPO Medical (HMSA Network, NMHC Drug, RSN ChiroPlan) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Kaiser Comprehensive HMO Medical and Drug, RSN ChiroPlan | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | EUTF HMO Medical (HMSA Network and Drug, RSN ChiroPlan). | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Kaiser Basic HMO Medical and Drug, RSN ChiroPlan | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | EUTF High Deductible Health Plan (HMSA Network and Drug) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | EUTF Supplemental Medical (HMSA Network), NMHC Drug, RSN ChiroPlan | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Royal State Supplemental Medical, RSN ChiroPlan | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | EUTF Prescription Drug (NMHC)Only | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Dental Plan | HDS Dental | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Vision Plan | VSP Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Life Insurance Plan | Standard Life Insurance | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

10. **STATE Employees Only (Premium Conversion Plan)** Enroll Do NOT Enroll Change amount Cancel PCP

11. Comments:

12. Certification (see instructions on back of this form)
Employee Signature: _____ **Date:** _____

13. DPO Signature: _____ Received Date: _____ DPO Phone: _____ DPO FAX: _____

14. Dept. ID# _____ 15a. Dept: _____ 15b. Division/School: _____ 16. Barg. Unit: _____



SUBMIT TO YOUR PERSONNEL OFFICE.

