



ENROLLMENT FORM

HAWAII LABORERS' HEALTH AND WELFARE TRUST FUND

PACIFIC ADMINISTRATORS, INC.

1440 Kapiolani Blvd., Suite 800 - Honolulu, Hawaii 96814

Phone: Oahu - (808) 441-8600; Neighbor Islands Dial Direct 1 (888) 520-8078; Fax: (808) 441-8750

Part I - THIS SECTION IS FOR MEMBER INFORMATION ONLY - PLEASE PRINT

LAST NAME			FIRST NAME IN FULL			MIDDLE NAME IN FULL			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE					
MAILING ADDRESS						CITY			STATE			ZIP CODE		
SOCIAL SECURITY NUMBER			<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE			THIS SECTION MUST BE COMPLETED			CHECK ONE DENTAL PLAN <input type="checkbox"/> HDS <input type="checkbox"/> GENTLE DENTAL					
DATE OF BIRTH		TELEPHONE NUMBER							CHECK ONE MEDICAL PLAN <input type="checkbox"/> HAWAII LABORERS SELF INSURED PLAN <input type="checkbox"/> KAISER PLAN					
MO	DAY	YR												

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			
						-		MO DAY YR			
BENEFICIARY'S MAILING ADDRESS				CITY		STATE		ZIP		BENEFICIARY'S TELEPHONE NO.	

Part III - SPOUSE INFORMATION - ATTACH COPY OF MARRIAGE CERTIFICATE

NAME (LAST, FIRST, MIDDLE INITIAL)			<input type="checkbox"/> HUSBAND <input type="checkbox"/> MALE <input type="checkbox"/> WIFE <input type="checkbox"/> FEMALE		SPOUSE'S SOCIAL SECURITY NO.		DATE OF BIRTH			
					-		MO DAY YR			
SPOUSE'S EMPLOYER			SPOUSE'S MEDICAL PLAN			<input type="checkbox"/> SINGLE PLAN <input type="checkbox"/> FAMILY PLAN		EFFECTIVE DATE OF COVERAGE		
								MO DAY YR		
COPY OF MARRIAGE CERTIFICATE ATTACHED			<input type="checkbox"/> YES <input type="checkbox"/> NO		IF YOUR SPOUSE'S MEDICAL INFORMATION CHANGES, YOU MUST CALL THE TRUST FUND OFFICE.					

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

Part IV - DEPENDENT CHILDREN - PLEASE ATTACH COPY OF BIRTH CERTIFICATE (S)								OFFICE USE ONLY		
CHECK ONE DAUGHTER SON	LIST NAMES OF ELIGIBLE DEPENDENTS LAST, FIRST, MIDDLE	DATE OF BIRTH			SOCIAL SECURITY NUMBER	COPY OF BIRTH CERT. ATTACHED	EFFECTIVE DATE OF COVERAGE			
		MONTH	DAY	YEAR			MONTH	DAY	YEAR	
1					- -	<input type="checkbox"/> YES <input type="checkbox"/> NO				
2					- -	<input type="checkbox"/> YES <input type="checkbox"/> NO				
3					- -	<input type="checkbox"/> YES <input type="checkbox"/> NO				
4					- -	<input type="checkbox"/> YES <input type="checkbox"/> NO				
5					- -	<input type="checkbox"/> YES <input type="checkbox"/> NO				
6					- -	<input type="checkbox"/> YES <input type="checkbox"/> NO				
7					- -	<input type="checkbox"/> YES <input type="checkbox"/> NO				
8					- -	<input type="checkbox"/> YES <input type="checkbox"/> NO				

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									

FOR OFFICE USE ONLY

PROCESSOR INFO.		AUDITOR INFO.		MEMBER ID NUMBER			
NAME:		NAME:					
DATE:		DATE:					

OTHER INSURANCE INFORMATION

If you and/or your dependents are covered under another health plan, it is very important that you complete the information below, which will allow us to properly coordinate benefits and may also help alleviate potential claim problems in the future.

Does another group health plan and/or Medicare cover you, your spouse, and/or any dependents that are also covered under your Hawaii Laborers Self-Insured plan? Yes No

- If yes:**
- If you and/or your dependent's other health plan is not Medicare, please complete sections 1 & 2.
 - If you and/or your dependent's other health plan is Medicare, please complete sections 1 & 3.
 - If you and/or your dependent's have other health plans plus Medicare, please complete sections 1, 2 & 3.

If no: - Please complete section 1 and sign your name.

SECTION 1 - TO BE COMPLETED BY ALL HAWAII LABORERS SELF-INSURED SUBSCRIBERS

Last Name, First Name	Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired	Date of Retirement (if applicable)
Social Security Number	Birth Date	Phone Number
I certify that the information furnished by me on this form is true and correct at this time, and agree to inform the Trust Fund Office of any changes.		
Member Signature		Date:

SECTION 2 - OTHER HEALTH PLAN INFORMATION

Name of Subscriber	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date	Social Security #	Relationship to Hawaii Laborer Subscriber
Name of Other Health Plan				Policy Identification Number
Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired	Employer's Name			Date of Retirement (if applicable)

Type of Coverage – Please check all that apply

<input type="checkbox"/> Medical Effective Date: _____	<input type="checkbox"/> Drug Effective Date: _____	<input type="checkbox"/> Single Plan
<input type="checkbox"/> Dental Effective Date: _____	<input type="checkbox"/> Vision Effective Date: _____	<input type="checkbox"/> Family Plan

List of Dependents Covered Under Other Health Plan (For additional dependents, please attach list)

Name (Last, First)	Relationship to you	Name (Last, First)	Relationship to you

SECTION 3 - MEDICARE COVERAGE INFORMATION

Name of Medicare Beneficiary	Social Security Number
Medicare Number (HICN Number):	Medicare Eligibility Due to: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End-Stage Renal Disease <input type="checkbox"/> Other: _____
Part A Effective Date: _____	
Part B Effective Date: _____	
Part D Effective Date: _____	
Part D Carrier: _____	

If you have any questions or concerns, please feel free to contact the Member Services Department at (808) 441-8700 on Oahu or Neighbor Islands toll-free at (888) 520-8078, Monday through Friday between the hours of 8:00 A.M. to 4:30 P.M.