

**EC-2**

rev July 2009

Hawaii Employer-Union Health Benefits Trust Fund

**ENROLLMENT FORM FOR RETIREES**

Customer Service: Oahu (808) 586-7390

Toll Free: 1 (800) 295-0089

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 Name, M.I.

3b. Social Security Number (for new enrollees only)  
or EUTF ID Number:3c. Mailing Address (  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 benefit plans, please complete sections 5 - 9.**

3g. Marital Status:

 Married  Single

3h. Gender:

 Male  Female

3i. Birth Date:

(MM/DD/YY) / /

3j. Home Phone

Number:

3k. Cell Phone Number

5a. Add 5b. Delete 6a. Dependents:  
First Name, M.I., Last Name (if different)6b. Birth Date  
(MM/DD/YY)6c. SSN  
or EUTF  
ID Number

7. Relationship

8. Gender: Check box as  
appropriate

/ /

 Male  Female

/ /

 Male  Female

/ /

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

Plan Section	Carrier Selection	Self	2-Party	Family	Waive/cancel
<b>Medical Plan</b> (Only one selection is allowed from this list)	EUTF PPO Medical (HMA Network)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	EUTF PPO Medical (HMSA Network)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Kaiser Comprehensive (HMO Medical and Drug)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Prescription Drug</b> (Not a valid selection with Kaiser HMO)	Informed Rx Prescription Drug	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Dental Plan</b>	Hawaii Dental Service - Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Vision Plan</b>	Vision Service Plan - Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Life Insurance Plan</b>	Standard Life Insurance - Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. If you or your dependent(s) are enrolled in a non-EUTF Medicare Part D prescription drug plan, please read item 10 on the back of this form and enter the name(s) of those enrolled in a non-EUTF Medicare Part D plan.

11. Retiree Certification (see instructions on the back of this form)

Retiree Signature: \_\_\_\_\_ Date: \_\_\_\_\_

12. **Medicare PART B enrollment:** Chapter 87A-23(4), HRS requires eligible beneficiaries to enroll in Medicare Part B as a condition of receiving contributions and participating in the EUTF benefit plans. If you or your dependent(s) recently enrolled in Medicare Part B, and have not already done so, please submit a copy of the Medicare card and complete this section to initiate quarterly reimbursement.

Name of enrollee:

Medicare Claim #: \_\_\_\_\_ (ID number listed on the blue and red Medicare Card)

**Please submit your signed and completed form via mail or hand delivery to:  
EUTF, P.O. Box 2121, Honolulu, Hawaii 96805-2121 or you may fax it to 808-586-2161.**

