Hawaii Electricians Health & Welfare Fund
1935 Hau Street Rm 300, Honolulu, HI 96819
(808) 841-6169 or (800) 622-3830 for neighbor islands.

Spouse / Dependent Questionnaire

Complete this questionnaire and return to our office as soon as possible. Failure to return this form may delay enrollment for you and/or your family for health benefits.

EMPLOYEE INFORMATION

Last Name, First, MI:	Date of Birth:	Social Security #:
Address:	Home Phone #:	Cell Phone #:

Matrial Status:

- ☐ Single
- ☐ Married — Date of Marriage: ___/___/___ *Attach copy of marriage certificate
- ☐ Divorced — Date of Divorce: ___/___/___ *Attach copy of divorce decree
- ☐ Legally Separated — Date of Separation:___/___/___ *Attach copy of order of separation

FAMILY INFORMATION

Spouse Last Name, First, MI:	Date of Birth:	Social Security #:

Is spouse employed? Yes____ No____
Check One: ☐ Full Time ☐ Part Time (# of hours/week)_______ ☐ Self Employed
Spouse's Employer:____ Start Date:________
Employer's Address:____
Employer's Phone #:______________________

Child's First Name (Last name, if different)	Relation	Date of Birth	Social Security #	Child Live with you	Full Time Student	Employed F/T or P/T (# of Hrs/Wk)
				Y/N	Y/N	
				Y/N	Y/N	
				Y/N	Y/N	
				Y/N	Y/N	
				Y/N	Y/N	
				Y/N	Y/N	
				Y/N	Y/N	

IMPORTANT: If any of the above dependent children are from a previous marriage, out-of-wedlock or step-children, call the Health & Welfare Fund Office as soon as possible.

OTHER HEALTH INSURANCE COVERAGE

1. Do you (the employee) currently have any other health insurance coverage including Medicare?
Yes ____ No ____ If "Yes", please provide the following information:

*Insurance Carrier:	Subscriber Name:	Policy No:	Effective Date:	Termination Date:

Type of coverage under this carrier: (Circle) Supplemental Medical / Medical / Drug / Vision / Dental

2. Does your spouse or any of your dependents have any other coverage including Medicare?
Yes ____ No ____ If "Yes", please provide the following information:

Type of	*Insurance Carrier:	Subscriber Name:	Policy No:	Effective Date:	Type of Plan Single/Family
Supplemental					
Medical					
Drug					
Vision					
Dental					

**Please provide a copy of your health insurance ID card, if possible.*

We understand that the Trust Fund is relying on our information on this form to determine eligibility for Trust Fund benefits for ourselves and our dependents. We understand that in providing our information on this verification form, it is unlawful for us to make any statements which we know are untrue, false or misleading. We declare and affirm in good faith and under penalty of perjury under Federal and State laws that the information we provided herein are true and correct to the best of our knowledge, and we consent to the provisions stated above on this form, which we have read and fully understand. We also understand that the penalty for committing perjury may be a fine or imprisonment, or both, and may also result in a legal claim against us for recovery or offset of benefits improperly paid to me based on the information we gave herein.

_______________________ _______________________ ____________
Employee Signature Spouse Signature Date

(rev. 6/08)