Keep a copy of the completed form for your records.

CHANGE OF ADDRESS FORM

Attn: COBRA COORDINATOR
Hawaii Employer-Union Health Benefits Trust Fund
P.O. Box 2121
Honolulu, HI 96805-2121

The undersigned is hereby providing notice to the COBRA Coordinator of the EUTF's group health plan(s) of a change in the mailing address of an employee, Qualified Beneficiary or other Plan Participant. The individuals identified below reside at the addresses shown below as of the date of this form.

Name	*Name*
Mailing address	*Mailing address*
City, State, Zip Code	*City, State, Zip Code*
Relationship to Employee	*Relationship to Employee*
Name	*Name*
Mailing address	*Mailing address*
City, State, Zip Code	*City, State, Zip Code*
Relationship to Employee	*Relationship to Employee*
Signature of Employee	Date
Name of Employee	Social Security Number of Employee