HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
P.O. BOX 2121
HONOLULU, HI 96805
HSTA VB RETIREES
EFFECTIVE JANUARY 1, 2017

		Monthly Premium HMSA	Monthly Premium Kaiser
1	**MEDICAL/PRESCRIPTION DRUG/CHIRO/VISION**		
A.	Non-Medicare - Self	☐ $683.42	☐ $713.20
B.	Non-Medicare - 2-Party	☐ $1,331.74	☐ $1,439.70
C.	Non-Medicare - Family	☐ $1,971.66	☐ $2,120.96
D.	Medicare - Self	☐ $445.96	☐ $450.16
E.	Medicare - 2-Party	☐ $869.16	☐ $878.14
F.	Medicare - Family	☐ $1,285.82	☐ $1,298.70

Select one plan and enter premium amount — **1** $ _____

		HDS
2	**DENTAL**	
	Non Medicare/Medicare	
	Self	☐ $44.42
	2-Party	☐ $86.54
	Family	☐ $105.94

Select one plan and enter premium amount — **2** $ _____

3 Add lines 1 and 2 — **3** $ _____

		0%	50%	75%	100%
4	**EMPLOYER CONTRIBUTION**				
A.	Non Medicare - Self	☐ $0.00	☐ $470.34	☐ $705.52	☐ $940.70
B.	Non Medicare - 2-Party	☐ $0.00	☐ $948.06	☐ $1,422.10	☐ $1,896.14
C.	Non Medicare - Family	☐ $0.00	☐ $1,387.60	☐ $2,081.40	☐ $2,775.20
D.	Medicare - Self	☐ $0.00	☐ $335.06	☐ $502.58	☐ $670.12
E.	Medicare - 2-Party	☐ $0.00	☐ $671.56	☐ $1,007.34	☐ $1,343.12
F.	Medicare - Family	☐ $0.00	☐ $978.12	☐ $1,467.18	☐ $1,956.24

Check your medical selection on line 1. (For example, if you selected 1A, your employer contribution will be non medicare self.) Enter your employer contribution amount (0% or 50% or 75%). — **4** $ _____

5 Line 3 minus line 4, enter the AMOUNT YOU OWE monthly — **5** $ _____

Please keep this sheet for your records. We do not send monthly billings or statements. Your monthly amounts will be on your confirmation notice. Payments are due by the first of the month, you may pay for more than one month of premiums on one check. Please make checks payable to EUTF and mail to P.O. Box 30700, Honolulu, HI 96820-0700.