Hawaii Employer-Union Health Benefits Trust Fund

Employee Address Change Form

Complete each section thoroughly, please print clearly	
Effective Date of Change:	EUTF ID or Social Security No.:

DEMOGRAPHIC INFORMATION

Full Name: ______________________________ Birthdate: ____/____/______
Last *First* *M.I.*

New Mailing Address: ______________________________
City *State* *Zip Code*

New Residence Address: ______________________________
City *State* *Zip Code*

Home Phone: (   ) ______________ Cell Phone: (   ) ______________ Email: ______________

This form is for address changes only. Any enrollment changes such as adding or deleting dependents must be reported on the EC-1/EC-1H (for HSTA VB members only) form, which is available on our website at eutf.hawaii.gov.

SIGNATURE

I certify that I am the person listed on this form and that my signature authorizes the EUTF to update my address as indicated above. This address change supersedes all previously submitted address changes.

______________________________ ______________
Signature *Date*

*Please submit your signed form to your departmental human resource officer or enrollment designee.
**For DOE employees, please submit your signed form to: DOE – EBU, PO Box 2360, Honolulu, HI 96804

------------------------------ Official Use Only ------------------------------

Department ID#	Department	Division/School	Bargaining Unit

Date Received in Office / /	DPO Phone Number	DPO Fax Number

DPO (or employer designee) Printed Name	Date of DPO (or employer designee) Signature / /
DPO (or employer designee) Signature	