Hawaii Employer-Union Health Benefits Trust Fund

Employee Address Change Form

County of Hawaii Only

All other employees must update their address through their personnel office or HIP (State Executive Branch, Legislative Branch, and HHSC)

Not for Retiree Use

Complete each section thoroughly, please print clearly

Effective Date of Change: _____ HB# or Social Security No: _____

DEMOGRAPHIC INFORMATION

Full Name: _____ Birthdate: _____
Last Name, First Name, Middle Initial

New Mailing Address: _____
City, State Zip Code

New Residence Address: _____
City, State Zip Code

Home Phone: _____ Cell Phone: _____ Email: _____

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 department human resource officer or enrollment designee

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			