



Hawaii Employer-Union Health Benefits Trust Fund
Active Employee Address Change Form

Not for Retiree Use

Complete each section thoroughly, please print clearly

Effective Date of Change:

Social Security No. or HB#:

DEMOGRAPHIC INFORMATION

Full Name: _____ Birthdate: _____
Last First M.I.

New Mailing Address: _____ New Residence Address: _____
City State Zip Code 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 department 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			