HAWAII ELECTRICIANS HEALTH & WELFARE FUND

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SPOUSE / DEPENDENT QUESTIONNAIRE

Please complete this form if you are a new member with dependents (spouse & child). Failure to submit this form may result in a delay of coverage for your dependents.

MEMBER NAME (Last, First, Middle Initial)	**Date of Birth**	**Social Security Number**
	/ /	

Address (Street, City, State, Zip Code)	**Telephone**
	Home ( )
	Cellular ( )

MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

(***Please attach a copy of marriage certificate or divorce decree***)

Effective Date: ______/______/______

SPOUSE NAME (Last, First, Middle Initial)	**Date of Birth**	**Social Security Number**
	/ /	

FOR H&W FUND OFFICE USE ONLY

❑ **NEW MEMBER** ❑ **ADD DEPENDENT(S)** ❑ **UPDATE/REV**

Date Rec'd ____________________

Member Identification No. ____________________

ELIG DATE ________________ COV EFFEC ________________

❑ M-CERT ❑ B-CERT ❑ SSN ❑ DECREE ❑ QMCSO ❑ ADOPT

REMARKS:

___ SYS36 / ____ MED / ____ RX / ____ DENTAL / ___ VISION

DEPENDENT CHILD(REN) NAME (Last, First, Middle)	**Gender**	**Date of Birth**	**Social Security**	**Child lives with:**	**Check all that applies:**	
	❑ Male ❑ Female	/ /		❑ You ❑ Other parent	❑ Employed ❑ Disabled	❑ Stepchild ❑ Legally Adopted
	❑ Male ❑ Female	/ /		❑ You ❑ Other parent	❑ Employed ❑ Disabled	❑ Stepchild ❑ Legally Adopted
	❑ Male ❑ Female	/ /		❑ You ❑ Other parent	❑ Employed ❑ Disabled	❑ Stepchild ❑ Legally Adopted
	❑ Male ❑ Female	/ /		❑ You ❑ Other parent	❑ Employed ❑ Disabled	❑ Stepchild ❑ Legally Adopted
	❑ Male ❑ Female	/ /		❑ You ❑ Other parent	❑ Employed ❑ Disabled	❑ Stepchild ❑ Legally Adopted
	❑ Male ❑ Female	/ /		❑ You ❑ Other parent	❑ Employed ❑ Disabled	❑ Stepchild ❑ Legally Adopted
	❑ Male ❑ Female	/ /		❑ You ❑ Other parent	❑ Employed ❑ Disabled	❑ Stepchild ❑ Legally Adopted

(Attach a copy of birth certificate for each dependent child)

SPOUSE EMPLOYER COVERAGE

Employment Status: ❑ Full Time ❑ Part-Time (Avg # of hrs/wk _______) ❑ Self-Employed **Occupation:** ____________________

Employer Name ____________________ **Address** ____________________ **Telephone** ( )

Does your spouse have health coverage through his/her employer? ❑ Yes ❑ No **Effective Date** ______/______/______

Carrier Name ____________________ **Group #:** ____________________ **Subscriber #** ____________________

Coverage Type:
☐ Medical ☐ Drug ☐ Dental
☐ Vision ☐ Supplemental

Plan Type:
(__) Single (__) Family
(__) Subscriber & Children

(List name(s) of all dependents covered under this plan)

____________________ ____________________ ____________________
____________________ ____________________ ____________________

(Attach a copy of your Membership Identification Card)

(Please complete and sign the page 2 of this questionnaire)

DEPENDENT CHILD EMPLOYER COVERAGE

Dependent Name: _____ **Date of Birth:** _____ **Social Sec #** _____

Employment Status: ❑ Full Time ❑ Part-Time (Avg # of hrs/wk _____) ❑ Self-Employed **Occupation:** _____

Employer Name _____ **Address** _____ **Telephone** ( ) _____

Does dependent have health coverage through his/her employer? ❑ Yes ❑ No **Type:** ❑ Medical ❑ Drug ❑ Dental ❑ Vision ❑ Supplemental

Carrier Name _____ **Group #:** _____ **Subscriber #** _____ **Effective** ___/___/___

(Attach a copy of your Membership Identification Card)

DEPENDENT CHILDREN / STEPCHILDREN COVERAGE

If any of your dependents are from a previous marriage, born out of wedlock or stepchild(ren), please complete the following:

Name of dependent child(ren): _____ _____ _____

Are any of the dependent children covered for health benefits under the other biological parent? ☐ **Yes** ☐ **No** **Effective Date:** ___/___/___

Name of the other biological parent: _____ **Date of Birth:** ___/___/___

Carrier Name: _____ **Policy No:** _____ **Subscriber ID#:** _____

MEDICARE COVERAGE

Name of person eligible for Medicare: _____ **Medicare No.** _____

Reason for Medicare: ❑ Age 65 or older ❑ Disability due to _____ ❑ ESRD / Date Dialysis Treatment Began: ____/____/____

Type of Coverage: Part A (Hospital) (_____/_____/_____) *Effective Date* Part B (Medical) (_____/_____/_____) *Effective Date* Part D (Drug) (_____/_____/_____) *Effective Date*

(Attach a copy of your Medicare Card)

OTHER COVERAGE

Subscriber Name: _____ **Subscriber ID #:** _____ **Effective Date:** ___/___/___

Carrier Name: _____ **Policyholder:** _____ **Group No:** _____

Coverage Type: ❑ Medical ❑ Drug ❑ Dental ❑ Vision ❑ Supplemental ❑ Retiree / **Plan Type:** **(__)** Single (__) Family (__) Subscriber & Spouse

(Attach a copy of your Membership Identification Card)

I/We understand that the Fund is relying on this information to determine eligibility for medical benefits for myself and my dependents. I/We understand that it is unlawful for me to make any statements which I/we know is untrue, false or misleading. I/We declare and affirm in good faith and under perjury under Federal and State laws that the information provided herein in true and correct to the best of my knowledge and I/We consent to the provisions stated above on this form which I/We have read and fully understand. I/We also understand that the penalty for committing perjury may be a fine or imprisonment, or both, and may also result in a legal claim against me for recovery or offset of benefits improperly paid to be or my dependents based on the information provided herein.

Member Signature **Date** **Spouse Signature** **Date**