DMBA

EMPLOYEE BENEFIT ENROLLMENT FORM FOR HAWAII

☐ New enrollment ☐ Mid-year change ☐ Dependent add/change ☐ Open enrollment

A. PARTICIPANT INFORMATION (REQUIRED–COMPLETE IN FULL)

Employee name: _____ DMBA ID number: _____

Employer name: _____ Employee Social Security number: _____

Birth date (MM/DD/YYYY): _____ Email: _____

Home address: _____ City: _____ State: _____ ZIP code: _____

Mobile/Primary phone: _____ Alternate phone: _____

Marital status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced Sex: ☐ Male ☐ Female

Spouse name and birth date: _____

B. CHOOSING YOUR BENEFITS

CHOOSE WHO TO ENROLL:

☐ Myself ☐ Myself and one dependent ☐ Myself and two or more dependents

CHOOSE YOUR MEDICAL PLAN (FSA eligible):

☐ Deseret Choice Hawaii ☐ Kaiser Hawaii ☐ Waive medical but keep Life and Disability

Note: If you wish to waive all benefits, see section C below.

CHOOSE YOUR DENTAL PLAN:

☐ Deseret Dental ☐ Deseret Dental *PLUS* ☐ Waive dental

CHOOSE YOUR VISION PLAN:

☐ VSP Vision Care ☐ Waive vision

C. PARTICIPANT AUTHORIZATION (REQUIRED)

☐ I wish to enroll or make changes as indicated on this form.

☐ I wish to waive all benefits. (Medical, dental, Group Term Life, Occupational Accidental Death & Dismemberment, Disability, and vision)

My signature acknowledges that I have read and agree to the terms and conditions of the benefits applied for herein. (For terms and conditions, see the summary plan descriptions at visit www.dmba.com.)

Signature: _____ Date: _____

D. EMPLOYER USE ONLY

Group Term Life (GTL) salary level REQUIRED: _____

Comments: _____

_____

_____

Action (check all that apply):

☐ New enrollment (hire date):

☐ Change or other: _____

☐ Leave of absence (specify type): _____

Employer authorization: _____ Date: _____

E. DEPENDENT INFORMATION

I wish to: ☐ Add dependent(s) ☐ Remove dependent(s)

Reason for change: _____

For dependent coverage, complete the following information. List your spouse and all legal dependents from oldest to youngest. **If you omit any dependents during initial enrollment, they will not be covered**.

RELATIONSHIP TO EMPLOYEE		NAME (FIRST, MIDDLE INITIAL, LAST)	BIRTH DATE (MM/DD/YYYY)	SEX	SOCIAL SECURITY NUMBER (REQUIRED)
S - Legal Spouse N - Natural or Adopted Child SC - Stepchild MC - Married Child GC - Grandchild O - Other (Specify in Comments)				M F	
				M F	
				M F	
				M F	
				M F	
				M F	
				M F	
				M F	
				M F	

Dependents added above will be enrolled for the coverage currently in effect. This includes the minimum guaranteed amounts only for Group Term Life and Supplemental Group Term Life. You may apply for additional Supplemental Group Term Life when the child is six months old. Also, new dependents will be enrolled for your current level of dependent coverage for 24-Hour Accidental Death & Dismemberment.

F. OTHER MEDICAL OR DENTAL COVERAGE

If you or any dependents are covered by any other medical or dental plan(s), please complete the following information or attach a copy of your health insurance card(s). If you no longer have your insurance cards, please contact your other insurance carrier to request a letter verifying your coverage and send it to DMBA.

Other insurance carrier name: _____ Phone number: _____

Policy holder: _____ ID number: _____

G. COMMENTS

Please return this completed form to enrollmenthelp@dmba.com. You may also mail it to DMBA, Attention: Member Services, P.O. Box 45530, Salt Lake City, UT 84145-0530 or fax it to 801-578-5933. For questions, visit www.dmba.com or call us at 801-578-5600 or 800-777-3622.