ENROLLMENT FORM INSTRUCTIONS & CHECKLIST

Please use this page as a guide to be sure you completed all the forms and sections within each form. Once you have checked off the necessary boxes, MAIL, FAX, OR HAND DELIVER THE ORIGINALS TO THE ADMINISTRATORS OFFICE

Enrollment Form (Front Page)

☐ Part 1: I completed this section with my information

☐ Part 2: I elected my Medical Plan

Part 3:

☐ I am married and want to cover my spouse: I completed this section and attached a copy of my Marriage Certificate.

OR

☐ N/A: I skipped this section because I am not married or do not want to add my spouse.

Part 4:

☐ I have child(ren): I completed this section and attached a copy of each natural child and/or stepchild's Birth Certificate or Hospital Certificate of Birth.
(For adopted child(ren), attach a copy of the Adoption Decree, Birth Certificate, and proof that the child currently resides in your home (ex: Income Tax Return).

OR

☐ N/A: I skipped this section because I do not have child(ren) or do not want to add my child(ren).

☐ Part 5: I signed my form

Other Insurance Information Form (Back Page)

☐ Section 1: I answered "NO" or "YES" to all 3 questions

☐ Section 2: (only for those who answered "YES" to any questions in Section 1): I entered other employer coverage information for myself, my spouse, or my dependents

Kaiser Arbitration Agreement: (REQUIRED FOR KAISER MEMBERS ONLY)

☐ I elected Kaiser and have signed the agreement.

OR

☐ N/A: I elected the Self Insured PPO Plan

Medicare Attestation Form

☐ Section 1: I answered "NO" or "YES" to all 3 questions

☐ Section 2: (only for those who answered "YES" to any questions in Section 1): I entered Medicare information for myself, my spouse, or my dependents

☐ Section 3: I printed my name and signed Section 3

Continued on next page

Beneficiary Designation Form

☐ Section 1: I completed this section with my information

Section 2:

- ☐ I checked off ALL 4 BOXES: I want all benefits assigned to the individuals listed on this form

OR

- ☐ I checked off only the benefits I want the individuals listed assigned to. (request another form for other benefits)

☐ Section 3: I listed the names of the person(s) I want named as my primary beneficiary.

☐ Section 4: I listed the names of the person(s) I want named as my secondary beneficiary.

☐ Section 5: I signed the form.

ENROLLMENT FORM

HAWAII LABORERS' HEALTH AND WELFARE TRUST FUND

PACIFIC ADMINISTRATORS, INC. -- 1440 Kapiolani Blvd., Suite 800 - Honolulu, Hawaii 96814
Phone: Oahu - (808) 441-8600; Neighbor Islands Dial Direct 1 (888) 520-8078; Fax: (808) 441-8750

(THIS FORM HAS 2 SIDES!)

Part 1 –MEMBER INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME	☐ MALE ☐ FEMALE

MAILING ADDRESS	CITY	STATE	ZIP CODE

SOCIAL SECURITY NUMBER		DATE OF BIRTH	PHONE NUMBER	EMAIL
__ __ __ - __ __ - __ __ __ __	☐ SINGLE ☐ MARRIED	__ __ / __ __ / __ __ __ __ MM DD YYYY		

Part 2 – MEDICAL PLAN ELECTION

(BOTH PLANS INCLUDE AUTOMATIC ENROLLMENT IN THE HAWAII DENTAL SERVICE DENTAL AND VSP VISION PLAN)

PLEASE SELECT ONE: ☐ **SELF-FUNDED COMPREHENSIVE PPO PLAN** (W/ OPTUMRX DRUG COVERAGE)

☐ **KAISER*** (W/ KAISER DRUG COVERAGE)

*** You MUST also sign the enclosed Kaiser Arbitration Agreement**

⚠ **IMPORTANT – KAISER PLAN ELECTION NOTICE:**

By selecting the Kaiser plan and signing the separate *Kaiser Arbitration Agreement*, you are agreeing to resolve most disputes with Kaiser through binding arbitration. This includes waiving your right to a jury trial, and may affect rights otherwise available to you under federal law, including ERISA. This arbitration requirement is imposed by Kaiser, not the Trust Fund. Please read the Kaiser Arbitration Agreement carefully before signing.

Part 3 – SPOUSE INFORMATION – ATTACH COPY OF MARRIAGE CERTIFICATE

NAME (LAST, FIRST, MIDDLE)	☐ MALE ☐ FEMALE	SOCIAL SECURITY NUMBER	DATE OF BIRTH
		__ __ __ - __ __ - __ __ __ __	__ __ / __ __ / __ __ __ __ MM DD YYYY

COPY OF MARRIAGE CERTIFICATE ATTACHED: ☐ Yes ☐ No

Part 4 – DEPENDENT CHILDREN INFORMATION- ATTACH COPY OF BIRTH CERTIFICATE(S)

	CHECK ONE M	F	LIST NAMES OF ELIGIBLE DEPENDENTS LAST	FIRST	MIDDLE	DATE OF BIRTH MM / DD / YYYY	SOCIAL SECURITY NUMBER	COPY OF BIRTH CERT. ATTACHED
1								☐ Yes ☐ No
2								☐ Yes ☐ No
3								☐ Yes ☐ No
4								☐ Yes ☐ No
5								☐ Yes ☐ No

Part 5 – ACKNOWLEDGEMENT AND SIGNATURE

☐ I acknowledge that all information on this form is true and correct, and that intentional falsification of information is a violation of Federal and State law and punishable by both civil and criminal sanctions.

☐ CHECK FOR KAISER MEMBERS ONLY: I am also enclosing with my Enrollment Form the signed Kaiser Arbitration Agreement

APPLICANT'S SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY

PURPOSE	100 HR WORK MOS	EFF DATE	MBR ID	THA PKG CODE	THA NOTES	SAVED REVVER	INITIAL PACKET
☐ INITIAL ☐ ADD DEP ☐ TERM ☐ UPDATE ☐ BC/MC REVVER DEP				☐	☐	☐	☐
☐ SELF DIRECTED PLAN CHANGE ☐ PRIOR PLAN MIN. 12 MOS?	INITIALS	DATE	NOTES:				

OTHER INSURANCE INFORMATION

THIS PART OF THE ENROLLMENT FORM MUST BE COMPLETED!

If you and/or your dependents are covered by another **EMPLOYER SPONSORED HEALTH PLAN**, it is very important that you complete the information below, which will allow us to properly coordinate your benefits and may also help to avoid potential claim problems or delays in the future.

SECTION 1: PLEASE ANSWER ALL 3 QUESTIONS BELOW:

	No	Yes
1. Do YOU have other coverage through another employer?	☐	☐
2. Do you have a COVERED SPOUSE who is working and covered by their employer?	☐	☐
3. Do you have a COVERED DEPENDENT who is working and covered by their employer?	☐	☐

If you answered NO to all 3 questions above, you are done!
If you answered YES to any of the above questions, complete Section 2

SECTION 2: COMPLETE THIS SECTION IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS

FOR MEMBER OR MEMBER'S SPOUSE WITH OTHER EMPLOYER COVERAGE:			
FULL NAME	RELATIONSHIP TO MEMBER		EMPLOYER NAME
	☐ Member ☐ Spouse		
OTHER HEALTH PLAN:	TYPE OF COVERAGE	Policy #	Date Coverage Started
☐ HMSA ☐ UHA ☐ HMAA ☐ KAISER ☐ OTHER_____	☐ Medical Only ☐ Medical & Drug		__ __ / __ __ / __ __ __ __ MM DD YYYY
OTHER DEPENDENTS COVERED BY ABOVE PLAN:			
1. Name (Last, First)			☐ Spouse ☐ Dependent
2. Name (Last, First)			☐ Dependent
3. Name (Last, First)			☐ Dependent
4. Name (Last, First)			☐ Dependent
5. Name (Last, First)			☐ Dependent
FOR ADULT DEPENDENTS WITH OTHER EMPLOYER COVERAGE:			
FULL NAME	RELATIONSHIP TO MEMBER		EMPLOYER NAME
	☒ Dependent		
OTHER HEALTH PLAN:	TYPE OF COVERAGE	Policy #	Date Coverage Started
☐ HMSA ☐ UHA ☐ HMAA ☐ KAISER ☐ OTHER_____	☐ Medical Only ☐ Medical & Drug		__ __ / __ __ / __ __ __ __ MM DD YYYY

FOR OFFICE USE ONLY			
MBR'S EFF DATE	ENTERED EZCAP	INITIAL	DATE

KAISER PERMANENTE®

This Agreement is **for Kaiser Members Only**. Kaiser members: Please read and sign at the end of pg. 3

Kaiser Foundation Health Plan, Inc., Hawaii Arbitration Agreement*

Binding Arbitration
Except as provided in the Dispute Resolution section of Kaiser Permanente's Guide to Your Health Plan (Guide) or by applicable law, any and all claims, disputes, or causes of action arising out of or related to your Guide or Evidence of Coverage (EOC), its performance or alleged breach, or the relationship or conduct of the parties, including but not limited to any and all claims, disputes, or causes of action based on contract, tort, statutory law, or actions in equity, shall be resolved by binding arbitration.

This includes but is not limited to any claim asserted:

By or against a Member, a patient, the heirs or the personal representative of the estate of the Member or patient, or any other person entitled to bring an action for damages, arising from or related to harm to the member or patient as permitted by applicable federal or Hawaii state law existing at the time the claim is filed ("Member Parties"). For purposes of this Agreement, all family members of the member or patient who have derivative claims arising from such harm, shall also be deemed "Member Parties" and bound to these arbitration terms; On account of death, bodily injury, physical ailment, mental disturbance, or economic loss arising out of the rendering or failure to render medical services or the provision or failure to provide benefits under this Agreement, except when binding arbitration is explicitly not permitted by applicable law, premises liability, or arising out of any other claim of any nature, irrespective of the legal theory upon which the claim is asserted; and

By or against one or more of the following entities or their employees, officers or directors ("Kaiser Permanente Parties"):

- Kaiser Foundation Health Plan, Inc.,
- Kaiser Foundation Hospitals,
- Hawaii Permanente Medical Group, Inc.,
- The Permanente Federation, LLC,
- Any individual or organization that contracts with an organization named above to provide medical services to Health Plan Members, when such contract includes a provision requiring arbitration of the claim made.

Notwithstanding any provisions to the contrary in this Agreement, the following claims shall not be subject to mandatory arbitration:

- claims for monetary damages within the jurisdictional limit of the Small Claims Division of the District Courts of the State of Hawaii;
- actions for appointment of a legal guardian of a person or property subject to probate laws;
- purely injunctive orders reasonably necessary to protect Kaiser Permanente's ability to safely render medical services (such as temporary restraining orders, and emergency court orders).
- claims that may not be subject to binding arbitration under applicable federal or state law;
- for Medicare members, claims subject to the Medicare appeals process.

Initiating Arbitration
A demand for arbitration shall be initiated by sending a registered or certified letter to each named party against whom the claim is made, with a notice of the existence and nature of the claim, the amount claimed and a demand for arbitration. Any Kaiser Permanente Parties shall be served by registered or certified letter, postage prepaid, addressed to the Kaiser Permanente Parties in care of the Health Plan at Kaiser Foundation Health Plan, Inc., Member Services, 711 Kapiolani Boulevard, Honolulu, HI 96813. The arbitrators shall have jurisdiction only over persons and entities actually served.

Arbitration Proceedings
Within 30 days after the service of the demand for arbitration, the parties shall agree on a panel of arbitrators from which to select arbitrators or shall agree on particular arbitrators who shall serve for the case. If the parties cannot agree on any panel of arbitrators or particular arbitrators within the 30 days, then the panel of arbitrators shall be that of Dispute Prevention and Resolution, Inc. ("DPR"). Unless the parties agree to any other arbitration service and rules, DPR shall

administer the arbitration and its arbitration rules shall govern the arbitration (including rules for selection of arbitrators from a panel of arbitrators, if the parties have not already agreed upon particular arbitrators to serve). Kaiser Permanente shall notify DPR (or such other arbitration service as may be chosen by the parties) of the arbitration within 15 days following the expiration of the 30-day period noted above.
Within 30 calendar days after notice to DPR, the parties shall select a panel of three arbitrators from a list submitted to them by the arbitration service. In all claims seeking a total monetary recovery less than $25,000.00, and in any other case where the parties mutually agree, a panel of one arbitrator selected by both parties from a list submitted to them by the arbitration service will be allowed. The arbitrator(s) will arrange to hold a hearing in Honolulu (or such other location as agreed by the parties) within a reasonable time thereafter.

Limited civil discovery shall be permitted only for production of documents that are relevant and material, taking of brief depositions of treating physicians, expert witnesses and parties (a corporate party shall designate the person to be deposed on behalf of the corporation) and a maximum of three other critical witnesses for each side (i.e., respondents or claimants), and independent medical evaluations.

The arbitrator(s) will resolve any discovery disputes submitted by any party, including entry of protective orders or other discovery orders as appropriate to protect the parties' rights under this paragraph.

Any payment for the fees and expenses of the arbitration service and the arbitrator(s) shall be borne one-third by the Member Parties and two-thirds by the Kaiser Permanente Parties. Each party shall bear their own attorney's fees, witness fees, and discovery costs.

The arbitrator(s) may decide a request for summary disposition of a claim or particular issue, upon request of one party to the proceeding with notice to all other parties and a reasonable opportunity for the other parties to respond. The standards applicable to such request shall be those applicable to analogous motions for summary judgment or dismissal under the Federal Rules of Civil Procedure.

In claims involving benefits and coverage due under this Agreement or disputes involving operation of the Plan, Health Plan's determinations and interpretations, and its decisions on these matters are subject to de novo review. The arbitration award shall be final and binding. The Member Parties and Kaiser Permanente Parties waive their rights to jury or court trial. With respect to any matter not expressly provided for herein, the arbitration will be governed by the Federal Arbitration Act, 9 U.S.C. Chapter 1.

General Provisions
All claims based upon the same incident, transaction or related circumstances regarding the same Member or same patient shall be arbitrated in one proceeding (for example, all Member Parties asserting claims arising from an injury to the same Health Plan Member, shall be arbitrated in one proceeding).

A claim for arbitration shall be waived and forever barred if on the date notice thereof is received, the claim, if it were then asserted in a civil action, would be barred by the applicable Hawaii statute of limitations. All notices or other papers required to be served or convenient in the conduct of arbitration proceedings following the initial service shall be mailed, postage prepaid, to such address as each party gives for this purpose. If the Federal Arbitration Act or other law applicable to these arbitration terms is deemed to prohibit any term in this Agreement in any particular case, then such term(s) shall be severable in that case and the remainder of this Agreement shall not be affected thereby. Class actions and consolidation of parties asserting claims regarding multiple members or patients are prohibited. The arbitration provisions in this Agreement shall supersede those in any prior Agreement.

Arbitration Confidentiality
Neither party nor the arbitrator(s) may disclose the substance of the arbitration proceedings or award, except as required by law or as necessary to file a motion regarding the award pursuant to the Federal Arbitration Act, in any federal or state court of appropriate jurisdiction within Hawaii, and in that event, the parties shall take all appropriate action to request that the records of the arbitration be submitted to the court under seal.

Special Claims
Medical Malpractice Claims Prior to initiating any arbitration proceedings alleging medical malpractice, Member Parties shall first submit the claim to a Medical Inquiry and Conciliation Panel pursuant to Chapter 671, Hawaii Revised Statutes, Sections 11-19. Following the rendering of an advisory decision by the Medical Inquiry and Conciliation Panel,

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if the claim has not been withdrawn or settled, Member Parties shall serve a demand for arbitration on Kaiser Permanente Parties as specified in the "Initiating arbitration" section.

Benefit Claims If the Member Party has a claim for benefits that is denied or ignored (in whole or in part), the Member Party may pursue legal action in federal or state court, as appropriate, after the Member Party has exhausted the claims and appeals process and, if applicable, external review process. The court will decide who should pay court costs and legal fees. If the Member Party is successful, the court may order the person or entity the Member Party has sued to pay these costs and fees. If the Member Party loses, the court may order the Member Party to pay these costs and fees, for example, if it finds the Member Party's claim is frivolous. If the Member Party has any questions about the Member Party's plan, the Member Party should contact Health Plan at 1-800-966-5955.

Although benefit-related claims may not be required to be resolved by binding arbitration pursuant to this section, Member Parties may still make a voluntary election to use binding arbitration to resolve these claims, instead of court trial, by filing a demand for arbitration upon Kaiser Permanente Parties pursuant to the provisions of the "Initiating Arbitration" section. If a voluntary election to use binding arbitration is made by a Member Party, the arbitration shall be conducted pursuant to the "Dispute Resolution" section of your Guide or EOC.

External Appeal of Internal Review Decisions If you disagree with Kaiser Permanente's final internal benefit determination, you may request voluntary binding arbitration pursuant to the procedures in this Agreement. In addition to the arbitration procedures set forth in this Agreement which may be elected by the Member (but are not mandatory), Hawaii Revised Statutes Chapter 432E also creates certain external review rights for Members to submit a request for external review to the State Insurance Commissioner within 130 days from the date of Kaiser's final internal determination. These rights are subject to the limitations noted in the next paragraph, and are subject to the requirements and limitations in Hawaii Revised Statutes Chapter 432E (including exhausting all of Kaiser Permanente's internal complaint and appeals procedures before requesting external review, except as specified in Chapter 432E for situations when simultaneous external review is permitted to occur or Kaiser Permanente has failed to comply with federal requirements regarding its claims and appeals process). A complete description of Kaiser Permanente's claims and appeals process is described in the "Appeals" section of your Guide or EOC.

Chapter 432E external reviews are limited to situations where (a) the complaint is not for allegations of medical malpractice, professional negligence or other professional fault by health care providers, and (b) the complaint relates to an adverse action as defined in Hawaii Revised Statutes Chapter 432E. Health Plan may object to external reviews under Chapter 432E which do not meet the standards for external review under applicable federal and state law and Health Plan reserves its full rights and remedies in this regard. The recitation of state law provisions shall not be deemed to constitute any waiver of such objections.

Senior Advantage Member Claims
Complaints and appeals procedures for Senior Advantage Members are described in the Kaiser Permanente Senior Advantage Evidence of Coverage (KPSA EOC). The arbitration provisions of this KPSA EOC apply only to Senior Advantage Member claims asserted on account of medical malpractice or a violation of a legal duty arising out of this KPSA EOC, irrespective of the legal theory upon which the claim is asserted.

_____ _____

Signature Required for all Kaiser Permanente Plans **Date**

_____

Print Member Name

Hawaii Laborers' Health & Welfare Fund Group #144

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MEDICARE ATTESTATION FORM
(MUST BE COMPLETED BY ALL MEMBERS)

Group health insurers, claims processing third-party administrators, and certain employer self-funded/self-administered plans report specific information about Medicare beneficiaries who have other group coverage to The Centers for Medicare & Medicaid Services (CMS). This reporting is to assist CMS and other health insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to answer the questions below to comply with this law.

NOTE: QUEST COVERAGE DOES NOT NEED TO BE DECLARED ON THIS FORM, ONLY MEDICARE

SECTION 1: PLEASE ANSWER ALL 3 QUESTIONS BELOW:

1. Are **you** presently, or have you ever been, enrolled in Medicare Part A or Part B?

   ☐ NO (skip to Section 3) ☐ YES (complete Section 2 & 3)

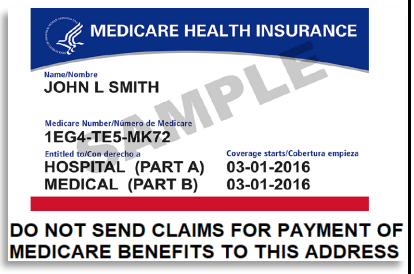
2. Do you have a **covered spouse** that is presently, or has ever been, enrolled in Medicare Part A or Part B?

   ☐ NO (skip to Section 3) ☐ YES (complete Section 2 & 3)

3. Do you have another **covered dependent** that is presently, or has ever been, enrolled in Medicare Part A or Part B?

   ☐ NO (skip to Section 3) ☐ YES (complete Section 2 & 3)

Please review this picture of the Medicare card to determine if you, your spouse, or dependents covered by your group health plan have, or has ever had, a Medicare card.



SECTION 2: If you answered "YES" to any of the questions above, please complete this section for each person who is, or has ever been, covered by Medicare. PLEASE NOTE: QUEST COVERAGE does NOT need to be declared here.

Full Name: (please print the name exactly as it appears on their SSN or Medicare card if available)

_____

Relationship (circle one): Member / Spouse / Dependent

Medicare Claim Number: _____ Date of Birth: ___ ___ / ___ ___ / ___ ___ ___ ___

Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Sex: ☐ Male ☐ Female

Full Name: (please print the name exactly as it appears on their SSN or Medicare card if available)

_____

Relationship (circle one): Member / Spouse / Dependent

Medicare Claim Number: _____ Date of Birth: ___ ___ / ___ ___ / ___ ___ ___ ___

Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Sex: ☐ Male ☐ Female

Section 3: Your signature is required for this form to be valid

I understand that the information requested is to assist my insurer, third-party administrator, or group health plan to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

_____ _____

Member Name Name of person completing this form (if not the Member)

_____ _____

Signature of person completing this form Date

HAWAII LABORERS' TRUST FUNDS

1440 KAPIOLANI BLVD., SUITE 800 - HONOLULU, HAWAII 96814 – Fax (808) 441-8750
PHONE (808) 441-8600 - NEIGHBOR ISLANDS DIAL DIRECT 1 (888) 520-8078
ANNUITY • HEALTH & WELFARE • LECET • PENSION • TRAINING • VACATION

NOTICE REGARDING BENEFICIARY DESIGNATIONS FOR HAWAII LABORERS':

- **Pension Fund**
- **Annuity Fund**
- **Vacation & Holiday Fund**
- **Health & Welfare Fund (Life Insurance)**

Dear Participant:

Please complete the attached Beneficiary Designation Form to ensure that your benefits are paid to the person(s) of your choosing, should they survive you. The information from this Beneficiary Designation Form is used to address the situation when a plan participant passes away **prior** to formal application for benefits.

Here are some tips to consider when completing the form:

- Section 2: Applicable Funds boxes
  - Check the box for each Fund to which you want the beneficiary designation to apply. If you do not check any boxes, the beneficiary designation will apply to all benefits you are eligible to receive from the Hawaii Laborers' Trust Funds
  - If you want to designate different beneficiaries for each Fund, you will need to request and submit a separate form for each Fund and check off the applicable Fund for each form.

- Section 3: Beneficiary Designation
  - If you list multiple beneficiaries, you must indicate the percentage amount for each. The percentage total for all beneficiaries must equal 100%.
    - If it does not equal 100% our office will contact you to revise the form.
    - If no further response is received, any unallocated amount will be distributed proportionately as indicated on the form. Any remaining balance due to rounding will be distributed to the first named beneficiary on the form.
    - If multiple primary beneficiaries are named, any unallocated amounts from beneficiaries no longer living will be distributed proportionately as indicated on the form.
  - Should your marital status change, you will need to complete a new Beneficiary Designation Form.
  - Failure to properly complete or update the form may result in death benefits being paid to someone other than the individual(s) of your choosing.

Other notes:

- If the Plan Administrator's Office does not have a Beneficiary Designation Form on file, the death benefit (if any) will be paid based on the applicable Plan rules.
- You may change your beneficiary(ies) at any time by submitting an updated Beneficiary Designation Form to our office.
- You may download this form by logging into your Hawaii Laborers' participant account or request a copy from our office.

Should you have any questions, please do not hesitate to contact the Plan Administrator's office at (808) 441-8600 or (888) 520-8078 toll free for neighbor islands.

(the Beneficiary Designation Form is attached)

HAWAII LABORERS' TRUST FUNDS

1440 KAPIOLANI BLVD., SUITE 800 - HONOLULU, HAWAII 96814 – Fax (808) 441-8750
PHONE (808) 441-8600 - NEIGHBOR ISLANDS DIAL DIRECT 1 (888) 520-8078
ANNUITY • HEALTH & WELFARE • LECET • PENSION • TRAINING • VACATION

BENEFICIARY DESIGNATION FORM (Pg. 1)

INSTRUCTIONS: All sections must be completed for processing. You must sign, date, and deliver this form to the administrator's office for the beneficiary designation form to be valid. **This form is valid when it is received by mail, in person or by fax**. This Beneficiary Designation Form cancels all prior designations. If you designate your spouse as your beneficiary and subsequently get divorced, your divorced spouses' beneficiary interest will be forfeited on the date of the divorce and your benefits will be distributed in the following order: (1) among the remaining surviving primary beneficiaries based on the proportions you provided, (2) if there are no surviving primary beneficiaries, your secondary beneficiaries you have listed, (3) to your next of kin in the following order, (i) your surviving spouse, (ii) your surviving children in equal shares, (iii) your surviving parents in equal shares, (iv) your surviving brothers and sisters in equal shares. If you wish to maintain your ex-spouse's beneficiary interest, you must complete another Beneficiary Designation Form.

SECTION 1: PARTICIPANT INFORMATION

Name	Social Security Number	Date of Birth	Telephone Number

Street Address	City	State	Zip	Email

Marital Status: ☐ Single ☐ Married (if married, please complete Spouse information below)

Spouse's Name	Social Security Number	Date of Birth	Telephone Number

SECTION 2: APPLICABLE FUNDS

Check the box for each Fund to which you want this beneficiary designation to apply. If you do not check any boxes, this beneficiary designation will apply to all benefits you are eligible to receive from the Hawaii Laborers' Trust Funds.

☐ **Hawaii Laborers' Pension Fund**
If you are married for at least one year prior to your death, but have not yet retired, your surviving spouse shall automatically be your beneficiary. If you have already retired at the time of your death, your designated beneficiary will receive your pension benefits.

☐ **Hawaii Laborers' Annuity Fund**
If you are married for at least one year prior to your death, your surviving spouse shall automatically be your sole beneficiary with respect to one-half (50%) of the Accumulated Share in your Individual Account payable upon your death for your Annuity Fund.

☐ **Hawaii Laborers' Vacation & Holiday Fund** *(Your accumulated vacation and holiday benefits.)*

☐ **Hawaii Laborers' Health and Welfare Fund** *(Group Term Life Insurance benefits)*

(please complete the back of this form!)

BENEFICIARY DESIGNATION FORM (Pg. 2)

SECTION 3: BENEFICIARY DESIGNATION

PRIMARY Beneficiary:

If you list more than one primary beneficiary, your benefits will be divided as you have indicated on this form based on your percentage allocations. If you don't indicate any percentages, your benefits will be divided equally among the listed primary beneficiaries. The percentage for all primary beneficiaries must equal 100%.

Name	Address	Date of Birth	SSN	Phone No.	Relationship	% of Benefit
					Must equal 100% ➡	100%

SECONDARY Beneficiary (applicable only if there is no primary beneficiary living at the time of the participant's death):

If you list more than one secondary beneficiary, your benefits will be divided as you have indicated on this form based on your percentage allocations. If you don't indicate any percentages, your benefits will be divided equally among the listed secondary beneficiaries. The percentage for all primary beneficiaries must equal 100%.

Name	Address	Date of Birth	SSN	Phone No.	Relationship	% of Benefit
					Must equal 100% ➡	100%

SECTION 4: PARTICIPANT'S CERTIFICATION AND SIGNATURE

I confirm and certify that the information above is true and correct, and that it expresses my choice(s) of designated beneficiaries. I am canceling all previous designations of beneficiaries for the above benefits.

Participant's Signature:_____ Date:_____