HAWAII PENSIONED OPERATING ENGINEERS
HAWAII DENTAL SERVICE (HDS) PLAN

1141 Harbor Bay Parkway, Suite 100
Alameda, California 94502-6594
1-800-251-5014 FAX 510-863-8373

ENROLLMENT FORM

_____ I wish to enroll when my coverage changes from the Active Plan to the Retiree Plan, OR

HAWAII DENTAL SERVICE (HDS) LOW OPTION

_____ I wish to have continuous coverage for myself only ($19.00 per month), OR

_____ I wish to have continuous coverage for myself + 1 Dependent ($36.10 per month), OR

_____ I wish to have continuous coverage for myself + more than 1 Dependent ($51.30 per month).

NOTE: Include your spouse and/or children up to age 19 (up to age 24 if proof is provided that your child is a student at an accredited educational institution and is taking nine or more units)

HAWAII DENTAL SERVICE (HDS) HIGH OPTION

_____ I wish to have continuous coverage for myself only ($39.30 per month), OR

_____ I wish to have continuous coverage for myself + 1 Dependent ($75.20 per month), OR

_____ I wish to have continuous coverage for myself + more than 1 Dependent ($107.20 per month).

NOTE: Include your spouse and/or children up to age 19 (up to age 24 if proof is provided that your child is a student at an accredited educational institution and is taking nine or more units)

Member Last Name, First Name (Please Print)	Social Security Number	Date of Birth
Spouse Last Name, First Name	Social Security Number	Date of Birth
Dependent Last Name, First Name	Social Security Number	Date of Birth
Dependent Last Name, First Name	Social Security Number	Date of Birth
Address (Street, City, State and Zip Code)	Area Code/Phone Number	

I understand that I must be eligible in accordance with plan rules for coverage. If I am eligible, I hereby authorize the Pension Trust Fund for Operating Engineers to deduct the required monthly amount from my pension check, and to pay this monthly amount to the Pensioned Operating Engineers' Dental Plan, for the purpose of providing dental benefits.

I understand that the Pensioned Operating Engineers' Dental Plan has no enforceable right in, or to my pension plan benefit payment or portion thereof, except to the payments actually received by the plan pursuant to this authorization. I also understand that once I enroll in the dental plan that I must remain enrolled for a minimum of twelve (12) months but once during the entire time that I am eligible under the plan, I may change plans before being in my current dental plan for 12 months. I also understand that if I cancel my enrollment in the Pensioned Operating Engineers' Dental Plan, I forfeit my right to reenroll in the dental plan.

Signature of Pensioner **Date**

***Any change in plans will be effective the first day of the second calendar month following the date the Trust Fund Office receives your enrollment form (per the Summary Plan Description).**

***Before allowing a dependent to be added to the Plan, the Trust Office requires all documentation such as marriage certificate, birth certificate, domestic partner certificate, divorce, or remarriage documents.**