Hawaii Carpenters Apprenticeship & Training Fund

Please complete the following form and submit to
hcatfhelpdesk@hicarpenterstraining.com

If submitting a change of address,
only page 1 of the document is needed.

HAWAII CARPENTERS TRUST FUNDS

200 N. VINEYARD BLVD, BLDG A, STE 100, HONOLULU, HI 96817 / PHONE (808) 841-7575 / NEIGHBOR ISLANDS 1 (800) 634-8608 / FAX (808) 841-2900 / HIPAA FAX (808) 772-5500

MEMBER INFORMATION FORM

I. PERSONAL INFORMATION:

Please check one: ☐ Active ☐ Retiree

Please be advised that any changes to personal information & marital status will be updated to all Trust Funds.

Last Name	First Name	Middle Initial	Date of Birth	Social Security Number
Mailing Address	Apt. #	City	State	Zip Code
( ) Home Phone	( ) Cell Phone	Email Address		Gender

II. MARITAL STATUS:

Please check one of the following:

☐ Single

☐ Married — If updating your marital status to married, please attach a copy of your certified Marriage Certificate. Please see Section VII of this form for the designation of Financial Security and 401(k) Fund beneficiaries.
Date of Marriage: _______________

☐ Divorced — If updating your marital status due to divorce, please attach a copy of your executed Divorce Decree and update your beneficiary designation, if needed. Date of Divorce: _______________

☐ Widowed — If updating your marital status due to the passing of your spouse, please attach your Spouse's Death Certificate and update your beneficiary designation, if needed. Date of Spouse's Death: _______________

III. NAME CHANGE: (If Applicable)

Legal court documents showing name change must be attached to this form.

☐ Member ☐ Spouse ☐ Dependent

OLD: _______________
Last Name First Name Middle Initial

NEW: _______________
Last Name First Name Middle Initial

IV. PLAN ENROLLMENT: (If Applicable)

Medical Plan (Choose One)	**Dental Plan**
☐ Indemnity Plan (Administered by HMSA) ☐ Kaiser Foundation Health Plan (available in the Hawaii Service Area only) By signing below, on behalf of myself and dependents, I confirm that I have read and understood the terms in Arbitration Agreement for Kaiser Foundation Health Plan-Hawaii (3-page attachment). I also agree to binding arbitration and waive my right to a jury trial.	Hawaii Dental Services (HDS)

V. DEPENDENT(S) INFORMATION: (If Applicable)

Eligible dependents include your legal spouse, and children under 26 years of age. Coverage under the Health & Welfare Fund is available to an eligible dependent without regard to marital status, dependency upon you (or anyone else) for financial support, residency with you, or full-time student status. The term "child" includes your natural child, step child, foster child, adopted child, or child placed for adoption. Eligible dependents may also include other individuals under age 26 who depend upon you for support and who are your dependents for federal income tax purposes. You must provide satisfactory proof to the Trust Fund office of their dependent status.
If adding a spouse, a copy of your Certified Marriage Certificate is required. If deleting a spouse, a full copy of your divorce decree is required. If adding a dependent, a copy of the child's Certified Birth Certificate is required (additional documentation may be accepted, please contact Trust Fund Office for more information). If deleting a dependent, please contact the Trust Fund Office for information.
Notes: Should there be any changes to your dependent's status, you are required to inform the Trust Fund Office immediately. If your dependent does not meet the dependent eligibility requirements, his/her coverage will be terminated. If you fail to inform the Trust Fund Office of the dependent's ineligibility, and the plan makes payments for services on behalf of an ineligible dependent, you must reimburse the plan for the amount of such payments.

Member Signature **Date**

(SEE REVERSE)

FOR TRUST FUND OFFICE USE ONLY	
Entered by:	____________
Date:	____________

V. DEPENDENT(S) INFORMATION (CONTINUED): (If Applicable)

To add more dependents than space permits here, list them on a separate sheet of paper. **Your signature and date are required on any separate sheets.** Please attach your separate sheet to this form and check the box to the right: ☐ More dependents attached

	Last Name	First Name	Middle Initial	Date of Birth	Social Security Number (Required)	Gender
☐ Add ☐ Delete	Spouse:					
☐ Add ☐ Delete	Dependent:					
☐ Add ☐ Delete	Dependent:					
☐ Add ☐ Delete	Dependent:					
☐ Add ☐ Delete	Dependent:					
☐ Add ☐ Delete	Dependent:					

VI. OTHER INSURANCE COVERAGE FOR YOU OR ANY ENROLLED DEPENDENTS: (If Applicable)

Are you or any of your dependents covered by any other Group Insurance? If yes, please provide us with the name of the other carrier, who is covered and his/her subscriber ID number below.

Covered Person(s)/Name:	Other Carrier(s):	Subscriber ID#:
________________	________________	________________
________________	________________	________________
________________	________________	________________
________________	________________	________________
________________	________________	________________
________________	________________	________________
________________	________________	________________

VII. BENEFICIARY DESIGNATION:

Please complete the beneficiary designation for all funds. If no beneficiary is designated for any Fund then the latest prior designation for that Fund will remain in effect unless a subsequent marriage requires payment to the surviving spouse. (Exception: See special instructions for the Financial Security Fund on the following pages.) Under the penalties of perjury, I certify by my signature below that all of the information on this beneficiary form is true, current, and complete. At least one Primary Beneficiary must be selected *for each fund.*

❖ HEALTH & WELFARE FUND:

PRIMARY BENEFICIARY

Beneficiary's Last Name	First Name	M.I.	Relationship to You	Date of Birth	Social Security #

Mailing Address	Apt. #	City	State	Zip Code	Telephone Number
					( )

CONTINGENT BENEFICIARY (OPTIONAL)

I hereby name the following person as Contingent Beneficiary should the Primary Beneficiary named above fail to survive me:

Beneficiary's Last Name	First Name	M.I.	Relationship to You	Date of Birth	Social Security #

Mailing Address	Apt. #	City	State	Zip Code	Telephone Number
					( )

★

Member Signature	**Print Name**	**Last 4 SSN**	**Date**

FOR TRUST FUND OFFICE USE ONLY

Entered by: ________________
Date: ________________

VII. BENEFICIARY DESIGNATION (CONTINUED):

❖ **FINANCIAL SECURITY FUND: See attached memorandum dated June 21, 2019**

- If you are legally married and have not received a distribution of your individual account at the time of your death, **50%** of your benefit will be paid to your surviving spouse with the remaining **50%** payable to your designated beneficiary (who could also be your spouse). Please provide your spouse's information in the "Automatic Spouse Beneficiary - For 50% of Benefit" section below. For the remaining 50% of benefit, provide your Beneficiary's name in "Primary Beneficiary - For Remaining 50% of Benefit" section below. Note that you may also name your spouse as beneficiary for this section.
- If you are single, your benefit will be paid to the beneficiary that you designate under the "Primary Beneficiary" section below. Should you wish to designate more than one (1) Primary Beneficiary, contact the Trust Fund office for an expanded form.
- Regardless of whether you are single or married, you may designate a "Contingent Beneficiary" in case you are not survived by your spouse or named Primary Beneficiary. Should you wish to designate more than one Contingent Beneficiary, contact the Trust Fund Office for an expanded form.

SINGLE

PRIMARY BENEFICIARY – For 100% of Benefit

I hereby name the following person as my Primary Beneficiary to receive 100% of my benefit should I die prior to receiving my benefit.

Note –

- If you marry after completing this form, your spouse will automatically become the beneficiary for 50% of your individual account balance, but you may designate a Primary Beneficiary and Contingent Beneficiary (either of whom could be your spouse) for the remaining 50% of your account (see MARRIED below).
- If you designate a minor as your Primary or Contingent Beneficiary, payment will be made to the minor's guardian (see attached Beneficiary Designation Rules memo).

Beneficiary's Last Name	First Name	M.I.	Relationship to You	Date of Birth	Social Security #

Mailing Address	Apt. #	City	State	Zip Code	Telephone Number
					( )

CONTINGENT BENEFICIARY (OPTIONAL)

I hereby name the following person as Contingent Beneficiary should the Primary Beneficiary named above fail to survive me.

Note – If there is no Primary or Contingent Beneficiary that survives you, Article IV, Section 6(c) of the Plan specifies the order in which classes of family members are eligible to receive payment of your benefit. If no listed family member survives you, payment will be made to your estate.

Beneficiary's Last Name	First Name	M.I.	Relationship to You	Date of Birth	Social Security #

Mailing Address	Apt. #	City	State	Zip Code	Telephone Number
					( )

MARRIED

AUTOMATIC SPOUSE BENEFICIARY – For 50% of Benefit

Note – If your spouse does not survive you, payment of the 50% spouse's portion of your individual account will be made to your Primary Beneficiary or if no Primary Beneficiary to your Contingent Beneficiary.

Spouse's Last Name	First Name	M.I.		Date of Birth	Social Security #

Mailing Address	Apt. #	City	State	Zip Code	Telephone Number
					( )

PRIMARY BENEFICIARY – For Remaining 50% of Benefit (may be your spouse)

I hereby name the following person as my Primary Beneficiary to receive 50% of my benefit should I die prior to receiving my benefit.

Note –

- If you wish to have your spouse also receive the remaining 50% of your benefit, you **must** specifically name your spouse below as your Primary Beneficiary.
- If you designate a minor as your Primary or Contingent Beneficiary, payment will be made to the minor's guardian (see attached Beneficiary Designation Rules memo).

Beneficiary's Last Name	First Name	M.I.	Relationship to You	Date of Birth	Social Security #

Mailing Address	Apt. #	City	State	Zip Code	Telephone Number
					( )

CONTINGENT BENEFICIARY (OPTIONAL) – For Remaining 50% of Benefit

I hereby name the following person as Contingent Beneficiary should the Primary Beneficiary named above fail to survive me.

Note – If there is no Primary or Contingent Beneficiary that survives you, Article IV, Section 6(c) of the Plan specifies the order in which classes of family members are eligible to receive payment of your benefit. If no listed family member survives you, payment will be made to your estate.

Beneficiary's Last Name	First Name	M.I.	Relationship to You	Date of Birth	Social Security #

Mailing Address	Apt. #	City	State	Zip Code	Telephone Number
					( )

★

Member Signature	**Print Name**	**Last 4 SSN**	**Date**

VII. BENEFICIARY DESIGNATION (CONTINUED):

❖ 401(k) FUND:

If you are legally married and would like to designate someone other than your legal spouse as your sole (or 100%) Primary Beneficiary, your spouse must sign below acknowledging and consenting that you have named someone else as your Primary Beneficiary. **YOUR SPOUSE'S SIGNATURE MUST BE NOTARIZED.** Should you wish to designate more than one (1) Primary or Contingent Beneficiary, contact the Trust Fund Office for an expanded form.

PRIMARY BENEFICIARY

Beneficiary's Last Name	First Name	M.I.	Relationship to You	Date of Birth	Social Security #

Mailing Address	Apt. #	City	State	Zip Code	Telephone Number
					( )

CONTINGENT BENEFICIARY (OPTIONAL)

I hereby name the following person as Contingent Beneficiary should the Primary Beneficiary named above fail to survive me:

Beneficiary's Last Name	First Name	M.I.	Relationship to You	Date of Birth	Social Security #

Mailing Address	Apt. #	City	State	Zip Code	Telephone Number
					( )

SPOUSAL CONSENT: (If Applicable)

I am the legal spouse of the above-named participant and I hereby consent to my spouse's beneficiary designation indicated above. I acknowledge and agree that by signing below, should I survive my spouse, I waive any rights to the portion of my spouse's Hawaii Carpenters 401(k) Fund benefits that is assigned to the beneficiary designated by my spouse on this form.

____

Signature of Spouse   Date

State of Hawaii
County of ________________

On this ________ day of _______________, 20_______, before me personally appeared ________________________, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

____

Signature of Notary Public   Date

My commission expires: ___________________________

❖ VACATION & HOLIDAY FUND:

PRIMARY BENEFICIARY

Beneficiary's Last Name	First Name	M.I.	Relationship to You	Date of Birth	Social Security #

Mailing Address	Apt. #	City	State	Zip Code	Telephone Number
					( )

CONTINGENT BENEFICIARY (OPTIONAL)

I hereby name the following person as Contingent Beneficiary should the Primary Beneficiary named above fail to survive me:

Beneficiary's Last Name	First Name	M.I.	Relationship to You	Date of Birth	Social Security #

Mailing Address	Apt. #	City	State	Zip Code	Telephone Number
					( )

★

Member Signature	**Print Name**	**Last 4 SSN**	**Date**

FOR TRUST FUND OFFICE USE ONLY

Entered by: ________________________
Date: ________________________