HSTA VEBA Voluntary Employees Beneficiary Association TRUST

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Dependent Information Sheet

Accident Insurance

Name (last, first, mi)

**Dependent(s):

Add	Delete	Disabled*	Last Name, First Name, MI	Birth Date (MM/DD/YY)	Relationship

I certify that the information provided is true and complete. I authorize HSTA-VEBA Trust to make changes to make deductions, adjustments or cancellations from my salary, wages, or other compensation to pay the premium for the coverage elected. I understand that my payroll deductions will change if my coverage or cost changes.

Member Signature: _____Date:_____

HSTA-VEBA Trust use	Effective/Change Date:	Cancellation Date:

****Dependent children from birth to age 19 or until their 23rd birthday if they are full-time students.**

Please Return Completed Form(s) to:
HSTA VEBA Trust
1259 Aala Street, Suite 202
Honolulu, Hawaii 96817
808-440-6940 / 1-800-637-4929
Fax: 808-440-6941