



**STATE OF HAWAII**  
**DEPARTMENT OF HEALTH**  
P. O. BOX 3378  
HONOLULU, HI 96801-3378

In reply, please refer to:  
File:

## **DOH NEW HIRE RECOMMENDED INFORMATION CHECKLIST**

### **YOUR PERSONAL INFORMATION**

- Contact Info.: Home/Mailing Address, Phone # (Cell/Home/other), E-mail Address
- Other: Social Security No., Citizenship and/or immigration status information, Federal & State Tax filing status & tax withholding, Marital Status, Former Name)
- Previous State and/or County Service: Department & Dates of Employment from-to

### **SPOUSE AND/OR DEPENDENT INFORMATION (if applicable)**

- Name(s): First, Middle, Last
- Address: Street/City/State/Zip
- Date of Birth: MM/DD/YYYY
- Social Security Number
- E-mail Address

### **CURRENT/OTHER HEALTH INSURANCE INFORMATION, (If applicable)**

- Plan Type
- Plan Name
- Subscriber's Name
- Effective Date

\*Initial Probation & Exempt Appointments ONLY

Click to View the most current [EUTF Summary of Health Benefits & Coverage](#)

### **BENEFICIARY INFORMATION – 2 REQUIRED**

(1 Primary Beneficiary & 1 Contingent Beneficiary)

- Name: First, Middle, Last
- Address: Street/City/State/Zip
- Date of Birth: MM/DD/YYYY
- Social Security Number
- E-mail Address
- Phone Number