

REGISTRATION OF RECIPROCAL BENEFICIARY RELATIONSHIP

STATE OF HAWAII

REGISTRANT ONE:

Name (Last, First Middle)

Date of Birth (Month, Day Year)

Address (Street)

City

State

Zip Code

Email Address

Phone Number

REGISTRANT TWO:

Name (Last, First Middle)

Date of Birth (Month, Day Year)

Address (Street)

City

State

Zip Code

Email Address

Phone Number

WE, THE UNDERSIGNED, DECLARE OUR INTENT TO ENTER INTO A RECIPROCAL BENEFICIARY RELATIONSHIP. ACCORDINGLY, WE WISH TO REGISTER OUR RECIPROCAL BENEFICIARY RELATIONSHIP WITH THE STATE OF HAWAII PURSUANT TO HAWAII REVISD STATUTES, CHAPTER 572C, AND ATTEST TO THE FOLLOWING:

- (1) Each of the parties is at least eighteen years old;**
- (2) Neither of the parties is married nor a party to another reciprocal beneficiary relationship;**
- (3) The parties are legally prohibited from marrying one another under chapter 572 (HRS); and**
- (4) Consent of either party to the reciprocal beneficiary relationship has not been obtained by force, duress, or fraud.**

WE AFFIRM/SWEAR THAT WE BOTH MEET THE ABOVE REQUIREMENTS OF A VALID RECIPROCAL BENEFICIARY RELATIONSHIP. WE HEREBY REQUEST THAT THE DIRECTOR OF HEALTH ISSUE US A CERTIFICATE OF RECIPROCAL BENEFICIARY RELATIONSHIP.

REGISTRANT ONE:

Signature

SUBSCRIBED AND SWORN TO BEFORE ME

This _____ day of _____, 20____

Notary Public

My commission expires _____

REGISTRANT TWO:

Signature

SUBSCRIBED AND SWORN TO BEFORE ME

This _____ day of _____, 20____

Notary Public

My commission expires _____

INSTRUCTIONS:

MAIL \$8.00 MONEY ORDER OR CERTIFIED CHECK PAYABLE TO STATE DIRECTOR OF FINANCE AND THIS COMPLETED REGISTRATION OF RECIPROCAL BENEFICIARY RELATIONSHIP FORM WITH SELF-ADDRESSED, LEGAL SIZED, STAMPED ENVELOPE TO:

**State Department of Health
Office of Health Status Monitoring
ATTN: RBR OFFICE
PO Box 3378
Honolulu, HI 96801**