_____
(Date)

☒ HMSA
ATTN: Membership Services
818 Keeaumoku Street
Honolulu, HI 96814

☐ Kaiser Permanente
ATTN: Federal Representative
P. O. Box 23758
San Diego, CA 92123

To Whom It May Concern:

This is to inform you of a change of family members to be covered under my family plan. Request my records be changed accordingly.

Identification as follows:

1. **Employing Office**: The Adjutant General, Hawaii
ATTN: HRO-M
3949 Diamond Head Road
Honolulu, HI 96816-4495

2. **Name and SSN**: _____

3. **Family member(s) to be added**:

Name(s)	*Relationship*	*DOB*	*SSN*

Date of marriage: _____

4. **Family member(s) to be deleted**:

Name(s)	*Relationship*	*DOB*	*SSN*

Date of Divorce: _____

Sincerely,

_____
(Signature)

_____
(Printed Name)

_____
(Address)

CF:
HRO-M