

Complete this form when making changes to your group's demographic information or adding/removing a Group Administrator. **Please note: This form is not for Online Access.** Sign up for access to UHA's Online Employer Services Portal by submitting an Online Agreement and Authorization Form or visit our website: uhahealth.com.

Group Name \_\_\_\_\_ Group Number \_\_\_\_\_

**Demographic Changes | Effective Date of Changes:**

**Physical Address:** \_\_\_\_\_  
(Street, City, State, Zip Code)

**Mailing Address:** \_\_\_\_\_  
(Street, City, State, Zip Code)

**Phone:** ( ) \_\_\_\_\_ **Fax:** ( ) \_\_\_\_\_ **Email:** \_\_\_\_\_

**Group Administrator(s) - Add/Remove/Update | Effective Date of Changes:**

**Action Required (check one):**  Add GA  Remove GA  Update GA Info

**Name:** \_\_\_\_\_ **Position Title:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_  
(Street, City, State, Zip Code)

**Phone:** ( ) \_\_\_\_\_ **Fax:** ( ) \_\_\_\_\_ **Email:** \_\_\_\_\_

**Group Administrator(s) - Add/Remove/Update | Effective Date of Changes:**

**Action Required (check one):**  Add GA  Remove GA  Update GA Info

**Name:** \_\_\_\_\_ **Position Title:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_  
(Street, City, State, Zip Code)

**Phone:** ( ) \_\_\_\_\_ **Fax:** ( ) \_\_\_\_\_ **Email:** \_\_\_\_\_

**(Agent must already be a Group Administrator, Owner, or Company Officer)**

**Authorized Group Administrator/Company Officer Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Authorized Group Administrator/Company Officer Name:** \_\_\_\_\_

**Please submit completed form to:** UHA Health Insurance  
Attn: Client Services Department  
700 Bishop Street, Suite 300  
Honolulu, HI 96813-4100  
Fax: 1-866-796-3484  
Email: clientservices@uhahealth.com