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Member Identification Card Request Form

Requester Information:

Date: _____

	Last Name	First Name	Initial
Requester's Name:			
Requester's Phone Number:			
Reason for Request:			

Subscriber Information:

	Last Name	First Name	Initial
Subscriber's Name:			
Subscriber's Social Security Number:	Subscriber's Group Number:		
Subscriber's Mailing Address: <i>(Must be the same as UHA's records)</i>			
Street Address:	City:	State:	Zip:
Subscriber's Phone Number:			

For UHA Use Only:

Date received:	
Date entered:	Entered by:
Date shipped	Shipped by:

Please Mail or Fax This Completed Form to:

Attention: Employer Services Department
 UHA
 700 Bishop Street, Suite 300
 Honolulu, Hawaii 96813

or

Fax: 877.222.3198