EC-1 BU12 Enrollment Form Instructions

Submit your completed EC-1 form to your personnel office or enrollment designee for verification, signature and routing to the EUTF within 30 days (180 days for newborns) of the event date.

Enrollment Type

Select the event for which you are submitting the enrollment form. Mark the New Hire box if you're newly hired, Qualifying Event box if you are making changes outside of the Open Enrollment period, or the Open Enrollment box during the annual or limited open enrollment period. If submitting the enrollment form for a qualifying event, give a brief description of the event and input the date the qualifying event occurred. Common qualifying events include: Acquisition of Coverage, Adoption, Birth, Civil Union Partner, Court Order, Death, Divorce, Domestic Partnership, Foster Child, Guardianship, Ineligible Student, Approved Leave of Absence Without Pay/Waive (LWOP/Waive), Approved Leave of Absence Without Pay/Re-enroll (LWOP/Re-enroll), Legal Separation, Loss of Coverage, Marriage, Moving Out of the Coverage Area, New Hire, Newly Eligible Employee, Newly Eligible Student, Reinstatement of Employment, or Termination of Domestic Partnership.

I. Employee Data

Complete all information about yourself and your spouse/partner.

II. Coverage Start Date

This section only needs to be completed if filing for new hire/newly eligible employee, adoption/placement for adoption, birth, marriage, domestic partner, guardianship, newly eligible student, reinstatement of employment, or return from authorized leave of absence (if not currently enrolled). Select one of the three choices for when your coverage and premium contributions will begin. If no selection is made, the first option will be the default option used.

III. Plan Selection

Mark all plans you wish to be enrolled in. You can choose one medical/prescription drug plan, one dental plan, and one vision plan. The prescription drug plan is bundled with the medical plan and will depend on the medical plan you select. If you do not want any plan coverage, mark the "Cancel/Waive" box. If no selection is made and you currently have coverage, EUTF will assume no changes are being made.

For State Employees Only: Premium Conversion Plan (PCP) is a voluntary benefit plan, administered by the Department of Human Resources Development (DHRD) that allows employees to purchase their health benefit plans on a pretax basis and is offered pursuant to Section 125 of the Internal Revenue Code. For more information, go to the DHRD website at dhrd.hawaii.gov. Please inquire with your DPO or DHRD on completing a PCP-2 form. Mark Enroll or Cancel/Waive on the EC-1 form.

For County Employees Only: Premium Conversion Plan (PCP) is administered by the Budget and Fiscal Services Department. Please contact your Department Personnel Office for more information on available options.

IV. Dependent Information

Complete dependent information and indicate plan selection if adding, removing or continuing coverage for dependents. If you are adding/removing more than five dependents and additional rows are needed, please attach another sheet to your enrollment form. Required supporting documents (e.g., marriage certificate, student certification letter, etc.) must be submitted to the EUTF within 60 days of the event date. If dependent children are age 19 to 23 and covered under your dental and/or vision plans, please submit certification from the school registrar or national clearinghouse indicating they are a full-time student. Detailed eligibility information is available online at eutf.hawaii.gov.

Use the following Relationship codes:

SP = Spouse	CH = Child	SC = Step Child
DP = Domestic Partner	DPCH = Domestic Partner's Child	GC = Guardianship or Foster Child
CU = Civil Union Partner	CUCH = Civil Union Partner's Child	DC = Disabled Child

V. Other Insurance Information

If you or your dependents are covered under another health plan, you are required to complete this section. The information that you provide does not determine how your benefits are coordinated. Coordination of Benefits rules are determined by the health benefit plans and follow the guidelines of the National Association of Insurance Commissioner (www.naic.org).

VI. Employee Signature

Read, sign and date the form. Submit your EC-1 form to your department human resource office or enrollment designee for verification, signature and routing to EUTF. To ensure proper processing, all required fields must be completed and proper documentation submitted timely.

Hawaii Employer-Union Health Benefits Trust Fund

Submit this form to HPD Finance Division.

ACTIVE EMPLOYEE
EC-1 HEALTH BENEFITS ENROLLMENT FORM

Bargaining Unit 12 (Police) Only

Clear Form

EMPLOYEE DATA

Complete each section thoroughly, please print clearly

Enrollment Type (*You must check one box*): **New Hire** ☐ **Qualifying Event** ☐ **Open Enrollment** ☐

New Hire or Qualifying Event Date: _____ **Qualifying Event Description:** _____

Full Legal Name: _____ (*Last* *First* *M.I.*) Social Security No. or EUTF ID No.: _____

Mailing Address: _____ (*City* *State* *Zip Code*)

Residence Address: _____ (*City* *State* *Zip Code*)

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner Marriage Date: _____

Gender: ☐ Male ☐ Female Birthdate: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Spouse/Partner Name: _____ SSN: _____ Birthdate: _____

COVERAGE START DATE

Complete this section if filing for new hire/newly eligible employee, adoption, birth, marriage, domestic partner, guardianship, newly eligible student, reinstatement of employment, or return from authorized leave of absence (if not currently enrolled).

☐ Coverage starts day of the event & premium contr butions start 1st day of the pay period in which the effective date of coverage occurs. **(If no selection is made, this option will be used.)**
☐ Coverage and premium contr butions start 1st day of the first pay period following event date (1st or the 16th of the month)
☐ Coverage and premium contr butions start 1st day of the second pay period following event date (1st or the 16th of the month)

PLAN SELECTION & CONTRIBUTIONS EFFECTIVE 7/1/18 THROUGH 6/30/19

Medical, Chiro and Prescription Drug Select one:				
HMSA PPO-90/10 Medical, RSN Chiro and CVS Prescription Drug Monthly Employee Premium	☐ Cancel/Waive	☐ Self $274.88	☐ Two-Party $690.40	☐ Family $896.00
HMSA PPO-80/20 Medical, RSN Chiro and CVS Prescription Drug Monthly Employee Premium	☐ Cancel/Waive	☐ Self $183.40	☐ Two-Party $461.64	☐ Family $599.40
HMSA PPO-75/25 Medical, RSN Chiro and CVS Prescription Drug Monthly Employee Premium	☐ Cancel/Waive	☐ Self $44.72	☐ Two-Party $111.70	☐ Family $144.66
HMSA HMO Medical, RSN Chiro and CVS Prescription Drug Monthly Employee Premium	☐ Cancel/Waive	☐ Self $368.36	☐ Two-Party $924.62	☐ Family $1,199.78
Kaiser HMO Comprehensive Medical, RSN Chiro and Prescription Drug Monthly Employee Premium	☐ Cancel/Waive	☐ Self $223.46	☐ Two-Party $562.12	☐ Family $729.68
Kaiser HMO Standard Medical, RSN Chiro and Prescription Drug Monthly Employee Premium	☐ Cancel/Waive	☐ Self $49.32	☐ Two-Party $123.24	☐ Family $159.62
RSN Supplemental Medical, RSN Chiro and Prescription Drug Monthly Employee Premium (Must have coverage under a non-EUTF health plan to be eligible for Supplemental)	☐ Cancel/Waive	☐ Self $17.02	☐ Two-Party $42.30	☐ Family $47.02
Dental Select one:				
Hawaii Dental Service Monthly Employee Premium	☐ Cancel/Waive	☐ Self $12.96	☐ Two-Party $25.92	☐ Family $42.66
Vision Select one:				
Vision Service Plan Monthly Employee Premium	☐ Cancel/Waive	☐ Self $2.60	☐ Two-Party $4.82	☐ Family $6.28
Life Select one:				
USAble Life Monthly Employee Premium	☐ Cancel/Waive	☐ Self $0		
Please contact your personnel office for more information on Premium Conversion or Flex Plan options.				

Employee's Name: _____

State and County Contributions: No person may be enrolled in any EUTF benefit plan as both a retiree/active employee and dependent, nor may children be enrolled on more than one retiree/active employee plan (dual enrollment). In addition, if you and your spouse/partner are both retirees/active employees, the employer's contribution cannot exceed a family plan contribution in accordance with Chapter 87A-32-36, Hawaii Revised Statutes. You and your spouse/partner are able to select EUTF self-only plans but by selecting self-only and 2-party plans or self-only and family plans you will exceed the employer's monthly contributions for a family plan.

DEPENDENT INFORMATION

Complete dependent information and indicate plan selection if adding/removing dependents.

Continue	Add	Delete	Last Name, First, Middle Initial	Birth date	SSN	Relationship	Gender	Medical/Rx	Dental	Vision
☐	☐	☐						☐	☐	☐
☐	☐	☐						☐	☐	☐
☐	☐	☐						☐	☐	☐
☐	☐	☐						☐	☐	☐
☐	☐	☐						☐	☐	☐

If dependents are age 19 to 23 and covered under your dental and/or vision plans, please submit certification from the school registrar or national clearinghouse indicating they are a full-time student. Detailed eligibility information is available online at eutf.hawaii.gov

OTHER INSURANCE INFORMATION

If you or any of your dependents are covered under another non-EUTF health plan(s), provide data below.

Type of Plan: (e.g. medical, dental)	Name of the Plan: (e.g. HMSA, Quest)	Subscribers Name(s):

EMPLOYEE SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand that the benefit elections made on this application are in effect as long as I continue to meet EUTF's eligibility requirements, or until I elect to change them subject to the provisions of EUTF's plan rules. I have read the benefit materials, understand the limitations and qualifications of the EUTF benefits program and agree to abide by the terms and conditions of the benefit plans elected.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages. I agree to immediately notify the Fund in writing of any changes that would result in the loss or change of elig bility of my or any of my dependent-beneficiary's benefits. I understand that the Fund reserves the right to terminate benefits and to seek recovery of any overpayment of benefits resulting from my failure to provide written notice within thirty (30) days of the event that caused the change or inelig bility. EUTF retains the right to terminate coverage in the event of non-payment, if payment is applicable. This form supersedes all forms and submissions previously made for EUTF coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that I am subject to penalties for perjury.

_____ _____

Employee Signature *Date*

---------- Official Use Only ----------

Department ID#	Department	Division/School	Bargaining Unit

Date Received in Office	DPO Phone Number	DPO Fax Number

DPO (or employer designee) Printed Name	Date of DPO (or employer designee) Signature

DPO (or employer designee) Signature

By signing this EC-1 form, I am attesting that this employee is eligible for EUTF benefits as per Chapter 87A, Hawaii Revised Statutes.

Comments: