EC-1 Rev July 2010	Hawaii Employer-Union Health Benefits Trust Fund **EC-1: Enrollment Form for Active Employees**	**PLEASE SUBMIT THIS FORM EC-1 TO YOUR PERSONNEL OFFICE**

SECTION 1: EMPLOYEE DATA

Please complete all applicable fields below.
Social Security numbers are required to process new employee and dependent enrollments

Name (Last, First, Middle)

____

☐ New Hire
Date of Hire ((MM/DD/YYYY)
_____/_____/_____
(☐ Check this box if status change)

☐ Mid- Year Qualifying Event (describe):
____
Event Date: _____/_____/_____

Work Phone (______) ______________________
Home Phone (______) ______________________
Mobile Phone (______) ______________________

☐ Open Enrollment

Marital Status ☐ Married ☐ Single
Marriage Date: (MM/DD/YYYY)
(☐ Check this box if status change)
_____/_____/_____

Residence Address (☐ Check this box if your address has changed)
Street______________________
Line 2______________________
City______________ State______ Zip Code________

Employee's Social Security Number (SSN) or EUTF ID Number
____

Domestic Partnership (DP Status)
☐ IRS Qualified ☐ Not Qualified
DP Date: (MM/DD/YYYY)(☐ Check this box if status change)
_____/_____/_____

Mailing Address (if different from above)
Street______________________
Line 2______________________
City______________ State______ Zip Code________

Gender ☐ Male ☐ Female
Birth Date: (MM/DD/YYYY)
_____/_____/_____

Special Note: If your Spouse or Domestic Partner is a State or County Employee or Retiree and is not being enrolled in your plans, please provide his/her SSN:______________________

SECTION 2: COVERAGE AND DEDUCTION START SELECTION

If events are filed within 30 days of qualifying event date, some events allow for a selection of the Coverage and Premium Contribution Start Dates.
If your event is listed below, please select one of the three options, otherwise skip this section.

Qualifying Events for this Section

Adoption, Birth, Marriage, New Domestic Partnership, New Hire, Newly Eligible, Placement for Adoption, Reinstatement in Employment, Return from Authorized Leave of Absence (if not currently enrolled)

Available Options for this Section

☐ Coverage starts day of the event & premium contributions 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 & premium contrib. start 1st day of the **first** pay period following event

☐ Coverage & premium contrib. start 1st day of the **second** pay period following event

Completed by DPO → *Effective Date of Coverage:* ______________ *Premium Contribution begins:* ______________

SECTION 3: PLAN SELECTION

Medical Plan ☐ **Cancel/Waive Medical Coverage** — **Choose only one box in each plan section**

Type	Carrier Selection		Self	2-Party	Family
PPO	PPO-Health Management Associates **(HMA "90/10")** No Drug Coverage	w/ RSN ChiroPlan	☐	☐	☐
PPO	PPO-Hawaii Medical Service Association **(HMSA "80/20")** No Drug Coverage	w/ RSN ChiroPlan	☐	☐	☐
HMO	HMO-Hawaii Medical Service Association **(HMSA)** HMSA Drug Coverage Included	w/ RSN ChiroPlan	☐	☐	☐
HMO	HMO-Kaiser Basic Kaiser Drug Coverage Included	w/ RSN ChiroPlan	☐	☐	☐
HMO	HMO-Kaiser Comprehensive Kaiser Drug Coverage Included	w/ RSN ChiroPlan	☐	☐	☐
HDHP	HDHP-High Deductible Health Plan **(HMSA)** HMSA Drug Coverage Included		☐	☐	☐
Supplemental	Supplemental-Hawaii Medical Service Association **(HMSA)** InformedRx Supplemental Drug Included	w/ RSN ChiroPlan	☐	☐	☐
Supplemental	Supplemental-Royal State National Insurance Company **(RSN)** RSN Supplemental Drug Included	w/ RSN ChiroPlan	☐	☐	☐

Other Plans

		Cancel/Waive	Self	2-Party	Family
Prescription Drug	InformedRx Prescription Drug (not a valid selection w/ the HMO, HDHP, or supplemental medical plans)	☐	☐	☐	☐
Dental	Hawaii Dental Service **(HDS)**	☐	☐	☐	☐
Vision	Vision Service Plan **(VSP)**	☐	☐	☐	☐
Life	Standard Insurance Company	☐	☐		

For STATE Employees ONLY: Premium Conversion Plan ☐ Enroll ☐ Do NOT Enroll ☐ Change Amount ☐ Cancel PCP

For COUNTY Employees ONLY: Premium Conversion Plan – Please contact your DPO for more information on available options

SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, DP=Domestic Partner, CH=your Child or your Spouse's Child, DPCH= Domestic Partner's Child, GC=Guardianship/Foster child, DC=Disabled Child if your child is age 19 or over and is also disabled.

Add	Delete	Dependent: Last Name (if different), First Name, Middle Initial	Birth Date (MMDDYYYY)	Social Security Number or EUTFID Number	*Relationship	Gender M/F	Medical	Drug	Dental	Vision
☐	☐		/ /				☐	☐	☐	☐
☐	☐		/ /				☐	☐	☐	☐
☐	☐		/ /				☐	☐	☐	☐
☐	☐		/ /				☐	☐	☐	☐
☐	☐		/ /				☐	☐	☐	☐
☐	☐		/ /				☐	☐	☐	☐
☐	☐		/ /				☐	☐	☐	☐

Detailed eligibility information is available at www.eutf.hawaii.gov in the EUTF Administrative Rules, Chapter 87A, Hawaii Revised Statutes.

Dependent Certification and Student Certification– See Section 4.6 and 4.7 of "Instructions for Completing Form EC-1" for more information.

I certify that all of my dependent children meet eligibility requirements for enrollment in the EUTF plans. ______ **(initials)**

I certify that all of my dependent children ages 19 through 23, are full time students at an accredited scholastic institution. ______ **(initials)**

Domestic Partner Certification – See Section 4.8 and 4.9 of "Instructions for Completing Form EC-1" for specific instructions.

I have attached all documentation as required in the Domestic Partner Enrollment Instructions. ______ **(initials)**

SECTION 5: OTHER INSURANCE INFORMATION

If you or any of your dependents are covered through another employer's health plan(s), please provide the type of plan, name of the plan, subscriber's name, effective date of the plan, and the health plan coverage (self, two-party, family, etc).

Type of Plan	Name of the Plan (Carrier's Name)	Subscriber's Name	Effective Date	Health Plan Coverage Self	2-Party	Family
			/ /	☐	☐	☐
			/ /	☐	☐	☐

SECTION 6: EMPLOYEE AUTHORIZATION AND SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand if I do not make a selection or check the "waive" box, it will be considered a "waive." I understand that the benefit elections made on this application are in effect for 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 selected. I authorize my employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from employee's salary, wages, pension or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

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. This form supersedes all forms and submissions I 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 penalty for perjury.

Employee Signature: ______________________________ Date Signed: ________________

Department ID#	Department	Division/School	Bargaining Unit
Date EC-1 Received in Employing Office / /		DPO Phone Number	DPO Fax Number
DPO (or employer designee's) Printed Name DPO (or employer designee's) Signature:			Date of DPO (or employer designee's) Signature / /
Remarks:			

Please print or type clearly. If the EC-1 form is unreadable, incomplete, or does not contain all information required, it may be sent back to you without action.

Submit the EC-1 form to your Personnel Office or Department Personnel Officer (DPO) for verification, signature, and routing.

SECTION 1 - EMPLOYEE DATA

1. Mark the New Hire box if:
   A) You are a new employee; and enter the effective date you were hired, or
   B) You are changing your employment status from part time (25% FTE) to full time (50% -100% FTE) employment; and enter the effective date you will become full time.
2. Mark the Open Enrollment box **only** during the annual or special Open Enrollment period.
3. Mark the Mid-Year Qualifying Event box if you have made any changes during the year; and enter the date of the event. The following are the most common events: Address Change, Birth, Divorce, Loss of Coverage, Acquisition of Coverage, Marriage, Retirement, Death, Termination, Transfer In, Transfer Out, etc. If there are simultaneous events, please describe the most prevalent event; for example, if the event is a birth and an address change, enter Birth in the event section.
4. Enter your full legal name as recorded on your Social Security card.
5. Enter your address information. If your mailing address differs from your residential address, you need to enter both addresses to ensure that correspondence reaches you timely.
6. If you are enrolling with the EUTF for the first time, you are required to provide your Social Security Number.

*** Section 7(b), of the Privacy Act of 1974 (Public Law 93—579) requires that any federal, state, or local governmental agency which requests an individual to disclose their Social Security account number shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it. The Hawaii Employer-Union Health Benefits Trust Fund (EUTF) requests each employee-beneficiary's Social Security account number on a voluntary basis. However, it should be noted that due to the use of Social Security account numbers by other entities for identification purposes, the EUTF may be unable to verify eligibility for benefits without the Social Security account number. The EUTF uses Social Security account numbers for the following purposes: 1. Employee-beneficiary identification for eligibility processing and eligibility verification; 2. Payroll premium deduction from paychecks for state/county employees; 3. Eligibility file to carriers; 4. Completion of 1099's for employee-beneficiaries with domestic partners. ***

SECTION 2 – COVERAGE AND DEDUCTION START SELECTION

1. If the "Qualifying Event" that applies to you is listed in Section 2 (adoption, birth, marriage, new domestic partnership, new hire, newly eligible, placement for adoption, reinstatement in employment, return from authorized leave of absence (if not currently enrolled)), you have three choices of when your coverage and premium contributions begin. Select one of the three.
2. If no selection is made, the first option (coverage starts day of the event and premium contribution starts first day of the pay period in which the effective date of coverage occurs) will be the default option selected.

SECTION 3 – PLAN SELECTION

1. Carefully review each selection that you make. You can choose ONE Medical, ONE dental, and ONE vision plan. Your choice of the prescription drug plan will depend on the MEDICAL plan that you select. If you select an HMO, HDHP, or a Supplemental plan, your medical selection also will include a prescription drug plan. If you select a PPO plan, you must select the prescription drug plan if you want drug coverage. If you don't make a selection, you will not have any prescription drug coverage.
2. You may now choose to elect only the Medical PPO plan without the Prescription Drug plan or vice versa. If you want both the medical and drug plans, please mark the appropriate boxes. Select one plan from the Medical plans and the appropriate coverage for you. If you do not want any plan coverage, mark the "Cancel/Waive" box. If you do not make a selection or check the "waive" box, you will be considered as "waiving" the selection(s). To be eligible for Supplemental Medical plan coverage, you must have other medical coverage from another source, not sponsored by your employer.
3. The RSN ChiroPlan is included with all medical plans except for the EUTF High Deductible Health Plan (HDHP).
4. If you have other health plan coverage and do not want to participate in the EUTF plans, mark the Cancel/Waive box for each plan that you choose not to select.
5. Life insurance is provided for the employee only.
6. FOR STATE EMPLOYEES ONLY: Premium Conversion Plan (PCP) - 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 being offered pursuant to Section 125 of the Internal Revenue Code. For more information, go to the DHRD website at http://hawaii.gov/hrd/. The PCP-2 form is not required for Open Enrollment. For all other qualifying events, please inquire with your DPO or DHRD on completing a PCP-2 form.
   -Mark one of the following boxes: ●Enroll, ●Do Not Enroll, ●Change Amount, or ●Cancel PCP.
   FOR COUNTY EMPLOYEES ONLY: Premium Conversion Plan (PCP) - PCP is administered by the Budget and Fiscal Services Department. Please contact your Department Personnel Office for more information.

SECTION 4 - DEPENDENT INFORMATION AND PLAN SELECTIONS

1. Enter your Dependent(s) data. If enrolling your dependent for the first time, enter his/her birth date and social security number. Otherwise, you may leave the birth date blank and list your dependent's EUTF ID number. If making changes to your

dependent's data, enter the corrected item. If listing more than 7 dependents, write/type "Continued" on the last line of the Dependent section. Attach a separate sheet of letter size paper to list additional dependent(s) information.

2. Use the following Relationship codes:

SP = Spouse	CH = Child	DC = Disabled Child√√
DP = Domestic Partner√	DPC = Domestic Partner Child√	GC = Guardianship or Foster Child√√√

3. For Relationship codes with √or √√or √√√, please see item #9 below for other required forms.
4. Gender - Mark either M or F.
5. Plan Selections. YOUR DEPENDENTS CAN BE ENROLLED ONLY IN THE SAME PLANS IN WHICH YOU ARE CURRENTLY ENROLLED. If you do not want any plan coverage for any of your dependents, mark the "Self" box in Section 3.
6. Dependent certification. Your initials confirm that you are certifying that all of your dependent children are eligible to be enrolled under your enrollment. You confirm that you will provide a copy of your child(ren)'s birth certificate and/or social security card if/when requested by the EUTF.
7. Student certification. Your initials confirm that you are certifying that all of your dependent children ages 19 through 23, are eligible to be enrolled under your enrollment as full-time students. You further confirm that you will provide proof of student status if/when requested by the EUTF.
8. If you are enrolling a domestic partner (and children), you are required to complete all required forms in accordance with the instructions for Domestic Partners. You are responsible to obtain, complete and submit all necessary documentation to the EUTF. Failure to do so will result in denying your domestic partner coverage. You may add your Domestic Partner at anytime outside of Open Enrollment provided all required documents have been received. Visit the EUTF website at eutf.hawaii.gov for detailed instructions regarding domestic partnership.
9. Other EUTF and/or DRHD forms to include with EC-1 (if applicable):
   - √ EUTF Declaration of Domestic Partnership or EUTF Declaration of Termination of Domestic Partnership
   - √ Affidavit of "Dependency" for Tax Purposes (For Domestic Partnerships)
   - √ DHRD Domestic Partnership Acknowledgement Form (State Employees with PCP enrolling Domestic Partners)
   - √ DHRD PCP 2 form (For State Employees Only)
   - √√ Disability Certification For Dependent Children (Form D-1) for enrolling a disabled child
   - √√√ Legal documents for guardianship or foster child

SECTION 5 – OTHER INSURANCE INFORMATION

1. If you or any of your dependents have health benefit coverage through another employer's health plan(s), you are required to complete this section. If you selected a supplemental medical plan, you are required to complete this portion.
2. The information that you provide does not determine how your benefits are coordinated. COB rules are determined by the health benefit plans and follow the guidelines of the National Association of Insurance Commissioners (www.naic.org).

SECTION 6 - EMPLOYEE AUTHORIZATION AND SIGNATURE

Your signature certifies that the information provided in this application is true and complete. You also agree to abide by the terms and conditions of the benefit plans selected. You are authorizing your employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from employee's salary, wages, pension or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

You must submit the EC-1 through your personnel office. Your personnel office confirms that you are a current employee and are eligible for health benefits through the EUTF.

EMPLOYER VALIDATION **[for EMPLOYER USE ONLY]**

- Department ID # - please enter your appropriate Department ID code; for example, 010021 for Department of Education, 010022 for University of Hawaii, 010053 for Budget and Finance, etc.
- Department and Division/School - Please enter the appropriate information.
- Bargaining Unit number - Please enter the appropriate bargaining unit for this employee.
- Enter the date the EC-1 was received from the employee. The date recorded should be the date that the **employer** received the Form EC-1, not the date the DPO/employer designee received it.
- Please provide contact phone and fax numbers.
- DPO/employer designee signature certifies that the employee-beneficiary is eligible for coverage through the EUTF as defined in Chapter 87A, Hawaii Revised Statutes.
- Enter date the EC-1 was signed by the DPO/employer designee.