

State of Hawaii Premium Conversion Plan Election Change Form

PERSONNEL OFFICE USE
Employer Receipt Date __ / __ / __
PCP Effective Date __ / __ / __
DPO Signature:

This form must be received by your employing department within **90 days** of a qualifying event. Changes/cancellations must be consistent with the event indicated and shall become effective on a **prospective** basis from the employer's receipt date. **NOTE: Changes/cancellations for DOMESTIC PARTNERS can only be made during the annual Open Enrollment Period.**

1. Name (Last, First, Middle)	2. Social Security Number (last 4-digits) XXX-XX-__ __ __	3. BU Code
4. Department	5. Division or School	
6. Business Phone	7. Date of Qualifying Event __ / __ / __	

PART A: Please check the benefits plan affected:

- Medical/Prescription Drug/Chiropractic
 Drug Only Plan
 Vision Plan
 Dental Plan

PART B: Action requested: Select box 1, 2, or 3 and the corresponding change in personal status.

1. I elect to **TERMINATE** my participation in the Premium Conversion Plan due to:
- Open Enrollment
 - My transfer to a non-eligible employment classification
 - My loss of eligibility for coverage under a component plan
 - I will be covered under my new second employer's health benefits plan or a new health benefits plan offered by my second employer
 - My marriage. I will be covered under my spouse's employer's plan
 - I will be covered as a dependent under my spouse's new employer's plan or retiree health benefits plan.
 - My spouse, who is also a State employee, changed his/her health plan enrollment to family coverage due to the birth/adoption of our child
 - I will be placed on a leave without pay status
 - Other (I have attached a written explanation)
2. I elect to **CHANGE** the amount of the PCP reduction of my pay from:
- Self-Only** to 2-party or Family enrollment; or **2-party** to Family enrollment because of:
- Open Enrollment
 - My Marriage
 - Birth or adoption of my child(ren)
 - My eligible dependent (re-)joined my household
 - My dependent's loss of eligibility for coverage under a health benefits plan
 - My spouse's health benefits plan is significantly changed or terminated
 - Other _____
- Family** to 2-party or Self-Only enrollment; or **2-party** to Self-Only because of:
- Open Enrollment
 - My Divorce/annulment of my marriage
 - Death of my dependent(s)
 - My last dependent child becoming ineligible for coverage
 - My spouse/dependent child becoming eligible for and electing coverage under another health benefits plan
 - Other _____
- Change of health benefits plan insurance carrier because my new residence is out of the service area of my present carrier.
- Change to a new employment classification where other component plans have become available or where my carrier's plan is not available.
3. I elect to **PARTICIPATE** in the Premium Conversion Plan, Self-Only 2-party Family enrollment
- My being out of State during the entire Open Enrollment Period My return from a leave without pay status
 - My loss of health benefits plan coverage because of the involuntary termination of my enrollment or my spouse's enrollment due to:
 - Death
 - Divorce/Annulment of my marriage
 - Eligibility/employment termination

PART C:

I understand that I am making an election that is binding for the remainder of the plan year. I also understand that during this period I may not modify my reduction in pay unless (1) the plan is terminated, (2) there is an increase in the amount of required employee contributions for the coverage which I have elected in conjunction with this current Election Change Form, or (3) there is a change in my personal status that qualifies under the Internal Revenue Code.

Employee Signature:	Date:
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