

State of Hawaii Premium Conversion Plan Election Change Form

PERSONNEL OFFICE USE
Employer Receipt Date
PCP Effective Date

This form must be filed with 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:
- | | |
|--|---|
| <input type="checkbox"/> Open Enrollment
<input type="checkbox"/> My transfer to a non-eligible employment classification
<input type="checkbox"/> My loss of eligibility for coverage under a component plan
<input type="checkbox"/> I will be covered under my new second employer's health benefits plan or a new health benefits plan offered by my second employer
<input type="checkbox"/> My marriage. I will be covered under my spouse's employer's plan | <input type="checkbox"/> I will be covered as a dependent under my spouse's new employer's plan or retiree health benefits plan.
<input type="checkbox"/> 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
<input type="checkbox"/> I will be placed on a leave without pay status
<input type="checkbox"/> 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:
- | | |
|--|---|
| <input type="checkbox"/> Open Enrollment
<input type="checkbox"/> My Marriage
<input type="checkbox"/> Birth or adoption of my child(ren)
<input type="checkbox"/> My eligible dependent (re-)joined my household | <input type="checkbox"/> My dependent's loss of eligibility for coverage under a health benefits plan
<input type="checkbox"/> My spouse's health benefits plan is significantly changed or terminated
<input type="checkbox"/> Other _____ |
|--|---|
- Family** to 2-party or Self-Only enrollment; or **2-party** to Self-Only because of:
- | | |
|--|---|
| <input type="checkbox"/> Open Enrollment
<input type="checkbox"/> My Divorce/annulment of my marriage
<input type="checkbox"/> Death of my dependent(s)
<input type="checkbox"/> My last dependent child becoming ineligible for coverage | <input type="checkbox"/> My spouse/dependent child becoming eligible for and electing coverage under another health benefits plan
<input type="checkbox"/> 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.

Signature:	Date:
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