

Print or type clearly. If this form is unreadable, incomplete, or does not contain all information required, it will be sent back to you without action.

SECTION 1 - RETIREE DATA

1. Enter your last name, first name, middle initial.
2. Enter your contact information.
3. 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.
4. Mark the Open Enrollment box **only** during the annual or limited Open Enrollment period.
5. Enter your gender and birth date.
6. Mark the Mid-Year Qualifying Event box if you are making changes during the year when it is not Open Enrollment; 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, 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.
7. If you are Married, or in a Civil Union, or in a Domestic Partnership please be sure to check the appropriate boxes and include the date you were Married, or entered in a Civil Union, or entered in a Domestic Partnership. You must attach a copy of required documents.
8. Special Note: If your Spouse or Civil Union Partner or Domestic Partner is a State or County Employee or Retiree, please provide his/her Social Security Number. Dual enrollment in HSTA VB plans is not allowed under EUTF Administrative Rule 4.03. If both you and your Spouse/Civil Union Partner/Domestic Partner are employee beneficiaries, only one of you may enroll in a HSTA VB Family plan, or if no other dependents are involved, both may enroll in HSTA VB Self plans. If your Spouse/Civil Union Partner/Domestic Partner has coverage outside of the EUTF that provides family coverage, this rule does not preclude you from also enrolling in a HSTA VB family coverage plan to cover your Spouse/Civil Union Partner/Domestic Partner. The dual enrollment rule does not apply if your other coverage is not provided by the EUTF.

SECTION 2 – COVERAGE AND CONTRIBUTION START SELECTION

Complete this section only if you pay towards health plan benefits

1. If the “Qualifying Event” that applies to you is listed in Section 2 [Adoption, Birth, Marriage, Civil Union, Domestic Partner, Placement for Adoption, Guardianship, New Eligible Student], 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.
3. The event date for Marriage and Civil Union is the marriage date or civil union certification date, respectively. The event date to add a Domestic Partner (DP) is the date the Declaration of DP is notarized.

SECTION 3 – PLAN SELECTION

Mark all plans you are enrolled in/want to enroll in.

1. Carefully review each selection that you make. You can choose ONE medical and ONE dental plan. Your choice of the prescription drug and vision plan will depend on the medical plan that you select.
2. If you have other health plan coverage and do not want to participate in the HSTA VB plans, mark the “Cancel/Waive” box for each plan that you choose not to select.
3. Life Insurance is provided by the state for the retiree only.

Write your name in the top right corner of page 2.

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. Social Security Number is not a required field when submitting an initial EC-2H for new birth. Please be sure to submit an EC-2H to update our records for your newborn once the information is received/issued by the Social Security Administration. Otherwise, you may leave the social security number 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 3 dependents, write/type “Continued” on the last line of the Dependent section. Attach a separate sheet of white letter sized paper to your EC-2H.
2. Use the following Relationship codes:
SP = Spouse CH = Child SC = Step Child
CU = Civil Union Partner ✓✓✓ CUCH = Civil Union Partner Child ✓ GC = Guardianship or Foster Child ✓✓
DP = Domestic Partner ✓✓✓✓ DPCH = Domestic Partner Child ✓✓✓ DC = Disabled Child ✓✓✓✓✓
3. For Relationship codes with ✓ or ✓✓ or ✓✓✓ or ✓✓✓✓, please see item #8 and #9 below for other required forms.
4. Gender – Write/type 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/Student certification. Your initials confirm that you are certifying that your spouse/partner and dependent children are eligible to be enrolled under your enrollment. You also confirm that you will provide a copy of your child(ren)'s birth certificate and/or social security card if requested by the EUTF. If you have dependent children between the ages of 19 through 23 who are full-time students, your initials confirm they are full time students at an accredited scholastic institution. You further confirm that you will provide a copy of your child(ren)'s student verification letter, signed by the registrar, as required by the EUTF.
7. Civil Union Partner Certification. Your initials confirm that you are certifying you have completed all the required forms in accordance with Civil Union.
8. Domestic Partner Certification. Your initials confirm that you are certifying you have completed all the required forms in accordance with Domestic Partnership.
9. If you are enrolling a Civil Union Partner (and Civil Union Partner's children) or Domestic Partner (and Domestic Partner's children), you are required to complete all required forms in accordance with the instructions for Civil Union Partner or Domestic Partner. You are responsible to obtain, complete and submit all necessary documentation within 30 days from your event date. Failure to do so will result in no action taken on your Civil Union Partner or Domestic Partner coverage. You may add your Civil Union Partner or Domestic Partner at anytime outside of Open Enrollment, provided all required documents have been received by EUTF within 30 days of the event date. Visit the EUTF website at eutf.hawaii.gov for detailed instructions regarding Civil Union Partnership or Domestic Partnership.
10. If you are adding a disabled child, domestic partner and child or an adopted child, please contact the EUTF at 808-586-7390 or toll free, 1-800-295-0089 or visit our website at eutf.hawaii.gov for more information. Other EUTF forms to include with EC-2H (if applicable):
 - √ Civil Union Certificate issued by the State of Hawaii Department of Health (printed copies of the temporary on-line certificate are acceptable)
 - √√ Legal documents for guardianship or foster child
 - √√√ EUTF Declaration of Domestic Partnership or EUTF Declaration of Termination of Domestic Partnership
 - √√√ Affidavit of "Dependency" for Tax Purposes
 - √√√√ Disability Certification For Dependent Children (Form D-1) for enrolling a disabled child

SECTION 5 – MEDICARE

IMPORTANT NOTICE: When you or your dependent(s) become eligible for Medicare Part B, you or your dependent(s) must enroll in Medicare Part B and forward proof of enrollment (Medicare card showing Medicare Part B effective date and Direct Deposit Authorization Form) to the EUTF. Failure to comply may result in loss of medical and prescription drug coverage.

SECTION 6 – RETIREE SIGNATURE

Your signature certifies that the information provided in this application is true and complete. Retiree agrees to abide by the terms and conditions of the benefit plans selected. Retiree affirms that any listed dependent child, aged 19 through 23, is attending a college, university or technical school as a full-time student and is also unmarried. Please enter date of Retiree's signature.

You must submit the EC-2H to the EUTF office. You may send it by mail or hand deliver. The addresses are printed at the bottom of page 2 of the enrollment form.

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

Name (Last, First, Middle Initial) _____ Home Phone (____) _____ Work Phone (____) _____ Mobile Phone (____) _____ Email _____ Residence Address <input type="checkbox"/> Check this box if your address has changed Street _____ Line 2 _____ City _____ State _____ Zip Code _____ Mailing Address (if different from above) Street _____ Line 2 _____ City _____ State _____ Zip Code _____	<input type="checkbox"/> Open Enrollment (effective 01/01/2016) Retiree's Social Security Number (SSN) or EUTF ID Number _____ Gender <input type="checkbox"/> Male <input type="checkbox"/> Female Birth Date: (MM/DD/YYYY) ____/____/____ Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single Marriage Date: (MM/DD/YYYY) <input type="checkbox"/> Check this box if status change ____/____/____	<input type="checkbox"/> Mid-Year Qualifying Event (describe) _____ Event Date: ____/____/____ Civil Union Partner (Civil Union Status) <input type="checkbox"/> IRS Qualified <input type="checkbox"/> Not Qualified Civil Union Date: (MM/DD/YYYY) <input type="checkbox"/> Check this box if status change ____/____/____ Domestic Partner (DP Status) <input type="checkbox"/> IRS Qualified <input type="checkbox"/> Not Qualified DP Date: (MM/DD/YYYY) <input type="checkbox"/> Check this box if status change ____/____/____
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Special Note: If your Spouse/Civil Union or Domestic Partner is a State or County Employee or Retiree, please provide the following:
 NAME: _____ SSN: _____ DOB: _____

SECTION 2: COVERAGE AND CONTRIBUTION START SELECTION	Skip this section if RETIREE does NOT pay towards health plan benefits.
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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, Civil Union, Domestic Partner, Placement for Adoption, Guardianship, New Eligible Student

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 and premium contributions start 1st day of the **first** pay period¹ following event

Coverage and premium contributions start 1st day of the **second** pay period¹ following event

¹ (1st or 16th of the month)

SECTION 3: PLAN SELECTION	Make your selection by checking all the boxes of the appropriate benefit plans below. Select Self, Two-Party, Family or Cancel/Waive coverage. Choose only one box in each plan selection. If no selection is made, EUTF will assume no changes are being made.
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Type	Carrier Selection	Choose only one box in each plan selection			
		Cancel/Waive	Self	2-Party	Family
Medical PPO	HSTA VB - PPO-90/10 HMSA Medical, Prescription Drug Coverage, Vision, Chiro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO	HSTA VB - HMO-Kaiser Medical, (Includes Kaiser Prescription Drug), Vision, Chiro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Plans		Cancel/Waive	Self	2-Party	Family
Dental	HSTA VB - Hawaii Dental Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Life	HSTA VB - USABLE Life	<input type="checkbox"/>	<input type="checkbox"/>	Not available to spouse/partner or dependents.	

Note: The enrollment of HSTA VEBA members into the health and other benefit plans created as a result of Judge Sakamoto's decision in the Gail Kono lawsuit is being solely done to comply with that decision and not to create any constitutional or contractual right to the benefits provided by those plans. Please note that the State does not agree with Judge Sakamoto's decision and reserves the right to move HSTA VEBA members into regular EUTF plans if that decision is overturned or modified.

SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS

Please list all dependents enrolled or who you want to add or delete from your plan.

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, CU=Civil Union Partner, DP=Domestic Partner, CH=your Child or your Spouse's Child, CUCH=Civil Union Partner's Child, DPCH= Domestic Partner's Child, GC=Guardianship/Foster child, SC = Step Child, DC=Disabled Child if your child is age 19 or over and is also disabled. Social Security Number **: Social Security Number is not a required field when submitting an initial EC-2H for new birth. Please be sure to submit an EC-2H to update our records for your newborn once the information received/issued by SSA.

Continue Coverage	Add	Delete	Dependent: Last Name (if different), First Name, Middle Initial	Birth Date (MMDDYYYY)	Social Security Number**	Relationship *	Gender M / F	Medical	Drug	Dental	Vision
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Detailed eligibility information is available at <http://eutf.hawaii.gov> in the EUTF Administrative Rules & Chapter 87A, Hawaii Revised Statutes.

Dependent Certification and Student Certification- See Section regarding Dependent and Student Certification on "Instructions for Completing Form EC-2H" for more information.

I certify that my spouse and/or dependent children meet eligibility requirements for enrollment in the EUTF/HSTA VB plans. _____ (initials)

Civil Union Partner Certification - See Section regarding Civil Union Partner Certification on "Instructions for Completing Form EC-2H" for specific instructions.

I have attached all documentation as required in the Civil Union Partner Enrollment Instructions. _____ (initials)

Domestic Partner Certification - See Section regarding Domestic Partner Certification on "Instructions for Completing Form EC-2H" for specific instructions.

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

SECTION 5: MEDICARE

HRS Chapter 87A-23(4) requires retirees and their dependents to enroll in Medicare Part B as a condition of receiving contributions and participating in the EUTF retiree benefit plans. If you or your dependent(s) are Medicare eligible and are not enrolled in Medicare Part B, you must enroll immediately and provide EUTF with a copy of your Medicare card. If you are already enrolled, be sure EUTF has a copy of your Medicare card.

SECTION 6: RETIREE 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 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

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.

Retiree Signature: _____ Date Signed: _____

Please submit your signed EC-2H form by mail to:

EUTF
P.O. Box 2121
Honolulu, HI 96805-2121

Customer Service Call Center

Oahu (808) 586-7390
Toll Free 1(800) 295-0089

Or you may hand deliver to: EUTF, 201 Merchant Street, Suite 1520, Honolulu, HI 96813