INSTRUCTIONS FOR COMPLETING FORM EC-1

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

Submit the Form EC-1 to your Personnel Office or Department Personnel Officer (DPO) for verification, signature, and routing to EUTF within 30 days (180 days for newborns) of the event date. For DOE Employees: You must submit your EC-1 form to the DOE-HBAU Office at PO Box 2360, Honolulu, HI 96804.

SECTION 1 - EMPLOYEE DATA

1. Enter your Last Name, First Name, and Middle Initial.
2. Enter your contact information.
3. Enter your address information. If your **residence** address differs from your **mailing** address, you must enter both addresses to ensure that correspondence reaches you.
4. Mark the New Hire/Newly Eligible box if:
   A) You are a new employee; and enter the effective date you were hired, or
   B) Your employment status is changing from part time (25% FTE) to full time (50% -100% FTE) employment; and enter the effective date you will become full time.
5. Mark the Open Enrollment box **only** during the annual or special Open Enrollment period.
6. Mark the Termination box if you are terminating your employment, and enter your last day of employment.
7. If you are enrolling with the EUTF for the first time, you are required to provide your Social Security Number and your dependent(s) Social Security Number.
8. Enter your gender and birth date. If enrolling for the first time, EUTF is unable to process your paperwork without a gender and a birth date.
9. Mark the Qualifying Event During the Plan Year 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, Change in Public Employer, 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.
10. If you are Married, in a Civil Union, or Domestic Partnership, please be sure to check the appropriate boxes and include the date you were Married, entered into a Civil Union, or entered into a Domestic Partnership. You must attach a copy of your civil union certificate received from the Department of Health or your marriage certificate. If you do not receive the certificate within 60 days of the date of the event, contact the EUTF. A notarized Declaration of Domestic Partnership form is required (form is available on the EUTF website).
11. Special Note: If your Spouse, Civil Union Partner or Domestic Partner is a State or County Employee or Retiree, please provide his/her Name, Date of Birth and Social Security Number on the corresponding line. Dual enrollment in EUTF plans is not allowed under EUTF Administrative Rule 4.03. No person may be enrolled in any EUTF benefit plan as both an employee-beneficiary and dependent-beneficiary, nor may children be enrolled by more than one employee-beneficiary (dual enrollment). In addition, if you and your spouse, domestic partner or civil union partner are both employee-beneficiaries, the employer contribution cannot exceed a family plan contribution in accordance with Chapter 87A-32(3), Hawaii Revised Statutes (HRS). However, both employee-beneficiaries are able to select EUTF Self-only 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 EUTF 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 DEDUCTION START SELECTION

1. If the “Qualifying Event” that applies to you is listed in Section 2 [Adoption, Birth, Guardianship, New Eligible Student, Marriage, Domestic Partner, Civil Union, New Hire, Newly Eligible, 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 contributions start 1st day of the pay period in which the effective date of coverage occurs) will be the default option selected.

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/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 that you select.
2. If you do not want any plan coverage, mark the "Cancel/Waive" box. 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. If no selection is made and you currently have coverage, EUTF will assume no changes are being made.
3. To be eligible for the Royal State Supplemental plan coverage, you must have other medical coverage from another source, not including this employer.
4. The RSN ChiroPlan is included with all medical plans, including the Royal State Supplemental plan.
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://dhrd.hawaii.gov. Please inquire with your DPO or DHRD on completing a PCP-2 form.
   -Mark one of the following boxes: ☐ Enroll, ☐ Change Amount, ☐ Cancel PCP, or ☐ Do NOT Enroll.

   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 on available options.

INSTRUCTIONS FOR COMPLETING FORM EC-1 (continued)

Please print clearly or type your name in the top right corner of page 2 of 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 (SSN). Social Security Number is not a required field when submitting an initial EC-1 for new birth. Please be sure to submit an EC-1 to update our records for your newborn once the information is received/issued by the Social Security Administration. Otherwise, you may leave the SSN 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 6 dependents, write/type "Continued" on the last line of the Dependent section. Attach a separate sheet of white letter sized paper to your EC-1.
2. 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 √√√√

3. For Relationship codes with a √ or √√ or √√√ or √√√√, please see below for other required forms.
4. Other EUTF and/or DRHD forms to include with EC-1 (if applicable):
   - √ Marriage or Civil Union Certificate issued by the State of Hawaii Department of Health (printed copies of the temporary on-line certificate are acceptable) and Affidavit of "Dependency" for Tax Purposes for Civil Unions
   - √√ Legal documents for guardianship or foster child
   - √√√ EUTF Declaration of Domestic Partnership and Affidavit of "Dependency" for Tax Purposes
   - √√√√ Disability Certification for Dependent Children (Form D-1) for enrolling a disabled child
   - √√√√√ Student certification if enrolling dependent age 19-23 in dental and/or vision plans
5. 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 to the EUTF through your employer 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. Additions of a Civil Union Partner or a Domestic Partner are permitted outside of Open Enrollment. For a New Civil Union submitted within 30 days from the date of the civil union, the effective date of coverage is based on the event date. For a New Domestic Partner submitted within 30 days from the date of notarized signature, the effective date of coverage is based on the date of the notary. Visit the EUTF website at eutf.hawaii.gov for detailed instructions regarding Civil Union Partnership or Domestic Partnership.
6. Gender – Write/type either M or F.
7. 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.
8. Dependent and Student certification. Your initials confirm that you are certifying that all of your 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. You also confirm that you will provide a copy of your child(ren)'s student verification letter on school letterhead, signed by the registrar, as required by the EUTF.

SECTION 5 – OTHER INSURANCE INFORMATION

1. If you selected the Royal State Supplemental plan, you are required to complete this section.
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).

Note: To be eligible for coverage under the Royal State Supplemental plan, you and your eligible dependent(s) must have health coverage through another source, not including this employer.

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 your salary, wages, 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. Your personnel office will forward your EC-1 to EUTF.

For DOE Employees: You must submit your EC-1 form to the DOE-HBAU Office at PO Box 2360, Honolulu, HI 96804.

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

1. 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.
2. Department and Division/School - Please enter the appropriate information.
3. Bargaining Unit number - Please enter the appropriate bargaining unit for this employee.
4. 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.
5. Please provide contact phone and fax numbers.
6. DPO / employer designee signature certifies that the employee-beneficiary is eligible for coverage through the EUTF as defined in Chapter 87A, Hawaii Revised Statutes.
7. Enter date the EC-1 was signed by the DPO / employer designee.

EC-1
Rev. April 2016

Hawaii Employer-Union Health Benefits Trust Fund

EC-1: Enrollment Form for Active Employees

DUE DATE: This form must be submitted to your Personnel Officer or Departmental Personnel Office within 30 days (180 days for newborns) of the event date.

PLEASE SUBMIT THIS EC-1 FORM TO YOUR PERSONNEL OFFICE DOE EMPLOYEES: HBAU PO BOX 2360 HONOLULU HI 96804

SECTION 1: EMPLOYEE DATA

Please complete all applicable fields below. Social security numbers are required to process new hires and dependent(s) enrollments. ** See Section 4 on "Instructions for Completing Form EC-1"

Name (Last Name, First Name, Middle Initial)

____

Home Phone (_____) ______________________________
Mobile Phone (_____) ______________________________
Work Phone (_____) ______________________________

Email ____

Mailing Address (☐ Check this box if your address has changed)

Street ____

Line 2 ____

City ____________________ State _______ Zip Code _______________

Residence Address (if different from above)

Street ____

Line 2 ____

City ____________________ State _______ Zip Code _______________

☐ New Hire/Newly Eligible
Date of Hire/Newly Eligible (MM/DD/YYYY)

_____/_____/__________

☐ Open Enrollment (effective 07/01/2016)

☐ Termination of Employment
Date of Termination (MM/DD/YYYY)

_____/_____/__________

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

____

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

_____/_____/__________

☐ During the Plan Year Qualifying Event (describe)

____

Event Date: _____ / _____ / _____

Marital Status ☐ Married ☐ Single
Marriage Date: (MM/DD/YYYY)

_____ / _____ / _____

☐ Civil Union
Civil Union Date: (MM/DD/YYYY)
(☐ Check this box if status change)

_____ / _____ / _____

Domestic Partner (DP Status)
☐ IRS Qualified ☐ Not Qualified
Notary Date: (MM/DD/YYYY)

_____ / _____ / _____

Special Note: If your Spouse, Civil Union Partner or Domestic Partner is a State or County Employee or Retiree, please provide his/her Name, Date of Birth and SSN:

Name: ______________________________________ DOB: _____/_____/__________ SSN: ______________________________

SECTION 2: COVERAGE AND DEDUCTION START SELECTION

If events are filed within 30 days of a 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, Guardianship, New Eligible Student, Marriage, Domestic Partner, Civil Union, New Hire, Newly Eligible, 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 and premium contributions start 1st day of the **first** pay period following event
☐ Coverage and premium contributions start 1st day of the **second** pay period following event

SECTION 3: PLAN SELECTION

Make your selection by checking all the boxes of the appropriate benefit plans below. Select Self, 2-Party, Family or Cancel/Waive coverage. You may only choose one medical/prescription drug plan. If no selection is made, EUTF will assume no changes are being made.

You may only choose one medical/prescription drug plan

Medical/Prescription Drug Plan Type	Carrier Selection	Cancel/Waive	Self	2-Party	Family
PPO	PPO-90/10 **HMSA** Medical, CVS Prescription Drug, RSN Chiro	☐	☐	☐	☐
	PPO-80/20 **HMSA** Medical, CVS Prescription Drug, RSN Chiro	☐	☐	☐	☐
	PPO-75/25 **HMSA** Medical, CVS Prescription Drug, RSN Chiro	☐	☐	☐	☐
HMO	HMO-**HMSA** CVS Prescription Drug, RSN Chiro	☐	☐	☐	☐
	HMO-**Kaiser** Standard Prescription Drug, RSN Chiro	☐	☐	☐	☐
	HMO-**Kaiser** Comprehensive Prescription Drug, RSN Chiro	☐	☐	☐	☐
Supplemental	Supplemental- Royal State National Insurance Company (Includes Supplemental Drug Coverage), Chiro *** To be eligible for coverage under the Royal State Supplemental plan, you and your eligible dependent(s) must be covered under a non- EUTF health plan. See Section 5 on "Instructions for Completing Form EC-1"	☐	☐	☐	☐

Other Plans		Cancel/Waive	Self	2-Party	Family
Dental	Hawaii Dental Service — if enrolling new dependent ages 19-23 attach student verification	☐	☐	☐	☐
Vision	Vision Service Plan — if enrolling new dependent ages 19-23 attach student verification	☐	☐	☐	☐
Life	USAble Life	☐	☐		

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

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

Employee's Name ____

SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS

Please list all dependents you want enrolled

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, DP=Domestic Partner, CU=Civil Union Partner, CH=your Child or your Spouse's Child, DPCH= Domestic Partner's Child, CUCH=Civil Union Partner's Child, SC=Step Child, GC=Guardianship/Foster 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-1 for new birth. Please be sure to submit an EC-1 to update our records for your newborn once the information received/issued by the SSA.

Continue Coverage	Add	Delete	Dependent: Last Name, First Name, Middle **Initial**	Birth Date (MM/DD/YYYY)	Social Security Number **	Relationship *	Gender M / F	Medical/ Drug	Dental	Vision
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐

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 4 item 8 on "Instructions for Completing Form EC-1" for more information.

I certify that my spouse, civil union or domestic partner and/or dependent children meet eligibility requirements for enrollment in the EUTF plans. ______ (initials)

I certify that my dependent child is a full-time student and have attached all documentation as required in Section 4 regarding dependent and student certification in the "Instructions for Completing Form EC-1". ______ (initials)

SECTION 5: OTHER INSURANCE INFORMATION

*** To be eligible for coverage under the Royal State Supplemental plan, you and your eligible dependent(s) must be covered under a non- EUTF health plan

If you or any of your dependents are covered under another non-EUTF 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, 2-party, Family).

Type of Plan	Name of the Plan (Carrier's Name)	Subscriber's Name	Effective Date	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 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 my salary, wages, 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:			