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, and middle initial.
2. Enter your contact information.
3. Enter your address information. If your residence address differs from your mailing 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. If you are enrolling with the EUTF for the first time as a retiree, you are required to provide your full Social Security Number.
6. Enter your gender and birth date. If enrolling for the first time, EUTF is unable to process your form without a birth date.
7. Mark the 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.
8. If you are married, or in a civil union or domestic partnership please be sure to check appropriate boxes and include date you were married or entered into a civil union or domestic partnership. You must attach a copy of required documents.
9. 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 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 used.
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, 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 Kaiser, your medical selection will include a prescription drug plan. If you select HMSA or UHC, you must select the prescription drug plan if you want prescription drug coverage. If you don't make a selection, you will not have any prescription drug coverage.
2. You may choose to elect only the medical PPO plan without the prescription drug plan or vice versa. If you want both the medical and prescription drug plans, please mark the appropriate boxes. If you do not want any plan coverage, mark the "Cancel/Waive" box.
3. 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.
4. Life Insurance is provided by the State/County 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. Social Security Number is not a required field when submitting an initial EC-2 for new birth. Please be sure to submit an EC-2 to update our records for your newborn once the information is received/issued by the Social Security Administration. 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-2.

2. Use the following Relationship codes:

SP = Spouse	CH = Child√√√√	GC = Guardianship or Foster Child √√
CU = Civil Union Partner √	CUCH = Civil Union Child √	SC = Step Child√√√√
DP = Domestic Partner √√√	DPCH = Domestic Partner Child √√√	DC = Disabled Child √√√√

If you are adding an Adopted Child, Civil Union Partner and child, Domestic Partner and child or a Disabled 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-2 (if applicable):

√ 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

√√ Legal documents for guardianship or foster child

√√√ EUTF Declaration of Domestic Partnership or EUTF Declaration of Termination 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

3. Gender – Write/type either M or F.
4. 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.
5. Dependent/Student certification. Your initials confirm that you are certifying that your spouse/partner and dependent children are eligible to be enrolled under your health plans. 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 ages 19 through 23 who are full-time students, your initials confirm they are full-time students at an accredited college or school. You further confirm that you will provide a copy of your child(ren)'s student verification letters required by the EUTF.
6. 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 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 any time 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.

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 – UNITEDHEALTHCARE MEDICARE ADVANTAGE PLAN

IMPORTANT NOTICE: You must be enrolled in Medicare Part A and B in order to enroll in the UNTEDHEALTHCARE Medicare Advantage plan.

1. For retiree-beneficiary, enter your full name as it appears on your Medicare card. If you are enrolling your spouse/partner, they must also enter their full name as it appears on their Medicare card.
2. Enter your Medicare claim number as it appears on your Medicare card. If you are enrolling your spouse/partner, they must also enter their Medicare claim number as it appears on their Medicare card.
3. End-Stage Renal Disease information is required for enrollment into the UnitedHealthcare Medicare Advantage plan. Please mark the appropriate box.
4. You can receive a full pre-enrollment kit by calling UnitedHealthcare or by attending one of the open enrollment meetings

SECTION 7 – RETIREE AND SPOUSE/PARTNER SIGNATURE

Your signature certifies that the information provided in this application is true and complete and you agree 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. If you are enrolling yourself **and your spouse/partner** in the UnitedHealthcare plan, your spouse/partner MUST provide a signature and date in section 7.

You must submit the EC-2 to the EUTF office within 60 days of the date of retirement. You may send it by mail or hand deliver. The addresses are printed at the bottom of page 2 of the enrollment form.

EC-2
Rev. Oct 2016

Hawaii Employer-Union Health Benefits Trust Fund

EC-2: Enrollment Form for Retirees

Clear Form

PLEASE SUBMIT THIS FORM EC-2 TO THE EUTF

SECTION 1: RETIREE DATA

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

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

☐ Newly Retired
Date of Retirement (MM/DD/YYYY)
/ /

☐ Open Enrollment (effective 01/01/2017)

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

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

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

☐ Qualifying Event (describe)

Event Date: / /

Civil Union Partner (Civil Union Status)
☐ IRS Qualified ☐ Not Qualified
Civil Union Date: (MM/DD/YYYY)
(☐ Check this box if status change)
/ /

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

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.

If events are filed within 30 days of the 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 period√ following event
☐ Coverage and premium contributions start 1st day of the second pay period√ following event
√ (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.

Choose only one box in each plan selection

Type	Carrier Selection	Cancel/Waive	Self	2-Party	Family	
Medical	PPO-90/10 HMSA Medical No Prescription Drug Coverage	☐	☐	☐	☐	
PPO	UnitedHealthcare Medicare Advantage Grp. 13840-Medicare A&B required No Prescription Drug Coverage	☐	☐	☐	☐	(All enrollees must be enrolled in Medicare Part A & B)
Prescription Drug	CVS Caremark Prescription Drug (Not a valid selection with Kaiser)	☐	☐	☐	☐	
HMO	HMO-Kaiser Medical (Includes Kaiser Prescription Drug)	☐	☐	☐	☐	
Dental	Hawaii Dental Service	☐	☐	☐	☐	
Vision	Vision Service Plan	☐	☐	☐	☐	
Life	USAble Life	☐	☐	Not available to dependents		

Print Form

Clear Form

Retiree's Name _____

SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS

Please list all dependents enrolled or who you want to add/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-2 for new birth. Please be sure to submit an EC-2 to update our records for your newborn once the information is received/issued by SSA.

Continue Coverage	Add	Delete	Dependent: Last Name (if different), 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 regarding Dependent and Student Certification on "Instructions for Completing Form EC-2" for more information.

I certify that my spouse/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-2". _____(initials)

SECTION 5: MEDICARE

HRS Chapter 87A-23(4) requires all Medicare eligible 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: UNITEDHEALTHCARE MEDICARE ADVANTAGE PLAN (UHC)

If you or any of your dependents are enrolling in the UnitedHealthcare Medicare Advantage Plan, YOU MUST COMPLETE THE INFORMATION BELOW (the information is on your red, white and blue Medicare card):

Retiree – Name of Beneficiary:_____Medicare Claim # __

Do you have End Stage Renal Disease (ESRD) ☐ Yes ☐ No

Spouse/Partner – Name of Beneficiary:_____Medicare Claim # __

Do you have End Stage Renal Disease (ESRD) ☐ Yes ☐ No

If the above information is not completed, your enrollment into the UnitedHealthcare Medicare Advantage Plan may be rejected resulting in no medical coverage.

SECTION 7: RETIREE & SPOUSE/PARTNER 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:_____

Retiree Spouse/Partner Signature:_____Date Signed:_____ (Signature & date required if enrolling in UHC)

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

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

Or you may hand deliver to: EUTF, 201 Merchant Street, Suite1700, Honolulu, HI 96813

Customer Service Call Center

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

Print Form