HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
AUTHORIZED LEAVE OF ABSENCE WITHOUT PAY (L-1)

Employee's Name (Last, First, M.I.) & Mailing Address	**EUTF ID or Social Security Number**
	Dates of authorized leave of absence without pay (start and end dates must be entered) **Start:** **End:**

Monthly Employee Contributions	
Medical (includes Chiropractic)	$__________
Prescription Drug	$__________
Dental	$__________
Vision	$__________
Total	$__________
Effective through* ____/____/____	

NOTE: Please review your pay statement each pay period to check whether premiums were deducted. If premiums are not deducted please submit your portion of the premiums to the EUTF to avoid cancellation of your plans.
For questions regarding your account balance, contact EUTF Accounting at 586-7390 or toll free at 1-800-295-0089, select option 3.

* Rates and contributions may change every July 1.

While on an authorized leave of absence without pay you must continue to pay your portion of your premiums, your employer will continue to pay their share of the premiums.

If your leave is expected to last more than one month (30 days), you have two options to choose from:

(1) Voluntarily cancel your health benefit plan enrollments due to leave without pay.

a. You must complete an EC-1 or EC-1H form within 30 days from the start of your leave of absence without pay to cancel your plans. The effective date of the cancellation shall be the end of the pay period during which the leave of absence without pay begins. All plans will be canceled except for the life insurance plan.
b. You may re-enroll in the same benefit plans upon return from the leave of absence without pay by completing an EC-1 or EC-1H form and submitting to your employer. The form must be submitted within 30 days of returning from the leave of absence.

(2) Continue your enrollments during your leave of absence without pay by paying the following premiums by the first of each month:

$ ______________

You may send payments in advance of your payment due dates. Make checks payable to "EUTF" and be sure to indicate your EUTF ID# and applicable month(s) on your check. Send your payments to:

EUTF
P.O. Box 30700
Honolulu, Hawaii 96820-0700

Additional payment options including credit card or electronic check payments are available. Please visit the EUTF website at www.eutf.hawaii.gov for information on how to make a payment online. Fees may apply.

NOTE: Failure to promptly pay your premiums may result in administrative cancellation of health plans. You will be ineligible for COBRA Continuation Coverage. If your enrollments are cancelled by the EUTF during your leave due to non-payment of premiums, you may re-enroll ONLY during the next open enrollment period and will suffer a break in coverage.

For DPO USE: Please route the completed Form L-1 by intra-office courier or mail to EUTF at P.O. Box 2121, Honolulu, Hawaii 96805-2121.

Employer ________________________ Agency/Department ________________________

DPO Signature ________________________ Date ____________ Phone ____________