INSTRUCTIONS FOR COMPLETING FORM EC-1H

Use of this form is for members currently enrolled in the HSTA VB plans. If you are not currently enrolled in the HSTA VB plans, please use the EC-1 form.

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

Submit the completed Form EC-1H to your Personnel Office (DOE EBU) at PO Box 2360, Honolulu, HI 96804 or your Charter School Personnel Office for verification, signature and routing to EUTF within 30 days (180 days for newborns) of the event date

SECTION 1 – EMPLOYEE DATA

1. Enter your Last Name, First Name, and Middle Initial.
2. Enter your contact information. Home phone number, Mobile phone number, Work phone number and email address.
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 Open Enrollment box **only** during the annual or special Open Enrollment period.
5. Mark the Termination box if you are terminating your employment and enter your last day of employment.
6. Enter your gender and birth date. EUTF is unable to process your paperwork without a gender and birth date.
7. Mark the Mid-Year Qualifying Event box if you have any changes during the year and enter the date of the event. The following are the most common events: Address Change, Birth, Divorce, Lost 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.
8. If you are Married, in a Civil Union, or Domestic Partnership, please be sure to check the appropriate box 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 EUTF. A notarized Declaration of Domestic Partnership form is required (form is available on the EUTF website).
9. **Special Note:** If you have a Spouse, Civil Union Partner or Domestic Partner 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

1. If the "Qualifying Event" that applies to you is listed in Section 2, 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 will be the default option selected.

SECTION 3 – PLAN SELECTION

1. Mark all plans you are enrolled in/want to enroll in.
2. 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.
3. 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.
4. The RSN Chiro Plan and Vision Service Plan (VSP) for vision are included with all medical plans.
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. Please inquire with your DPO or DHRD on completing a PCP-2 form. Mark one of the following boxes, Enroll or Do Not Enroll.

INSTRUCTIONS FOR COMPLETING FORM EC-1H (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). SSN is **not** a required field when submitting an initial EC-1H for new birth. Please be sure to submit an EC-1H 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-1H.
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 ✓✓✓✓ or ✓✓✓✓✓, please see below for other required forms.
   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

4. 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.
5. Gender – M or F
6. 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.
7. Dependents and Student Certification. You must provide a copy of your child(ren)'s birth certificate and/or social security card if requested by the EUTF. You also must 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 or your dependent(s) are covered under another health 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)
3. If you have ever been or are currently covered as a dependent under a state or county employee or retiree plan, please provide the state or county employee or retiree's Name, Date of Birth, and Social Security Number (SSN optional) on the corresponding line.

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.

For Charter School Employees: You must submit the EC-1H 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-1H to EUTF.

For DOE Employees: You must submit your EC-1H to the DOE-EBU 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.
2. Department and School/Office: Please enter the appropriate information
3. Bargaining Unit Number: Please enter the appropriate bargaining unit for this employee
4. Enter the date the EC-1H was received from the employee. The date recorded should be the date that the **employer** received the EC-1H form, not the date the Personnel Office (DOE-EBU) or Charter School/employer designee received it.
5. Please provide contact phone and fax numbers
6. Personnel Office (DOE EBU) or Charter School/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-1H was signed by the Personnel Office (DOE EBU) or Charter School /employer designee.

Clear Form

EC-1H Rev. 04/2017	Hawaii Employer-Union Health Benefits Trust Fund **EC-1H: Enrollment Form for HSTA VB Active BU 05/45 Employees** DUE DATE: This form must be submitted to DOE EBU within 30 days (180 days for newborns) of the event date.	DOE employees please submit this form to: DOE-EBU 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.

Name (Last Name, First Name, Middle Initial)

Home Phone (____) _____

Mobile Phone (____) _____

Work Phone (____) _____

Email _____

Mailing Address (☐ Check if your address has changed)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

Residence Address (☐ Check if address is different from above)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

☐ Open Enrollment (effective 07/01/2017)

☐ 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)

__/__/__

☐ Mid-Year Qualifying Event (describe)

_____

Mid-Year Qualifying Event Date: (MM/DD/YYYY)

__/__/__

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

__/__/__

☐ Civil Union (☐ Check if status changed)
Civil Union Date: (MM/DD/YYYY)

__/__/__

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

__/__/__

Special Note: If you are married, in a civil union or domestic partnership, please provide your spouse/partner's Name, Date of Birth, and SSN:

Name: _____ DOB: __/__/__ SSN: _____

SECTION 2: COVERAGE AND CONTRIBUTION START SELECTION

If your event is listed below, please select one of the three options, otherwise skip this section.

Some events allow for a selection of the Coverage and Premium Contribution Start Dates.

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.

Medical/Prescription Drug Plan			You may only choose one medical/prescription drug plan			
Type	Carrier Selection		Cancel/Waive	Self	2-Party	Family
PPO	PPO-90/10 HMSA Medical, CVS Prescription Drug, Vision, RSN Chiro		☐	☐	☐	☐
	PPO-80/20 HMSA Medical, CVS Prescription Drug, Vision, RSN Chiro		☐	☐	☐	☐
HMO	HMO-Kaiser Comprehensive Medical, Prescription Drug, Vision, RSN Chiro		☐	☐	☐	☐
Other Plans			Cancel/Waive	Self	2-Party	Family
Dental	Hawaii Dental Service	If enrolling new dependent ages 19-23, attach student verification	☐	☐	☐	☐
Supplemental Dental	Supplemental 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*			Do NOT Enroll	Enroll		
Premium Conversion Plan			☐	☐		

*The State allows its employees to pay for health premiums on a pre-tax basis. For more information please visit www.dhrd hawaii.gov

Note: The enrollment of HSTA VEBA members into the health and other benefits 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 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-1H for new birth. Please be sure to submit an EC-1H 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	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-1H" for more information.

SECTION 5: OTHER INSURANCE INFORMATION

If you or any of your dependents are covered under another non-EUTF health plan(s), provide the type of plan, name of the plan, subscriber's name, and dependents on the plan.

Type of Plan	Name of Plan (Carrier's Name)	Subscriber's Name	Are you on this plan?	Are all dependents listed in Section 4 on this plan? If no, list below which dependents are on this plan.
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

Have you ever been or are you currently covered as a dependent under a state or county employee or retiree plan? ☐ Yes ☐ No

If "Yes", please provide the information as requested below of the state or county employee or retiree:

Name: (Last Name, First Name, Middle Initial) _____ DOB: ____/____/____ SSN: (Optional) _____

SECTION 6: EMPLOYEE AUTHORIZATION AND SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form also meet the eligibility requirements for enrollment in the EUTF plans. 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	School/Office	Bargaining Unit
Date EC-1H Received in DOE EBU/Charter School (or employer designee's):		DOE EBU/Charter School Phone Number	DOE EBU/Charter School Fax Number
DOE EBU/Charter School (or employer designee's) Printed Name:			
DOE EBU/Charter School (or employer designee's) Signature: By signing this EC-1H form, I am attesting that this employee is eligible for EUTF benefits as per Chapter 87A, Hawaii Revised Statutes			Date of DOE EBU/Charter School Signature:
Remarks:			