Hawaii Employer-Union Health Benefits Trust Fund

EC-2H RETIREE HEALTH BENEFITS ENROLLMENT FORM
HSTA VB Retirees Only

Clear Form

Complete each section thoroughly, please print clearly			
Enrollment Type (*check one*):	Retirement ❑	Qualifying Event ❑	Open Enrollment ❑
Retirement or Qualifying Event Date:		Qualifying Event Description:	

I. RETIREE DATA

Full Name: _____ Social Security No.: _____
Last *First* *M.I.*

Mailing Address: _____ Residence Address: _____

_____ _____
City *State* *Zip Code* *City* *State* *Zip Code*

Marital Status: ❑ Single ❑ Married ❑ Domestic Partner Gender: ❑ ❑ Birthdate: _____
Marriage Date: _____ Male Female

Home Phone: _____ Cell Phone: _____ Email: _____

Spouse/Partner Name: _____ SSN: _____ Birthdate: _____

II. COVERAGE START DATE

Complete this section if filing for adoption/placement for adoption, birth, marriage, domestic partner, guardianship, or newly eligible student.

❑ 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 (1st or the 16th of the month)

❑ Coverage and premium contributions start 1st day of the second pay period following event (1st or the 16th of the month)

III. PLAN SELECTION

Make your selection by checking all the boxes of the appropriate benefit plans below. Choose only one box in each type category.

Type	Carrier Selection	Cancel/Waive	Self	2-Party	Family
Medical, Prescription Drug, Vision, and Chiro: *Choose ONE*	*HSTA VB - HMSA PPO-90/10 Medical and Chiro (CVS Prescription Drug, VSP Vision)*	❑	❑	❑	❑
	HSTA VB - Kaiser HMO Medical and Chiro (Kaiser Prescription Drug, VSP Vision)	❑	❑	❑	❑
Dental:	*HSTA VB - Hawaii Dental Service*	❑	❑	❑	❑
Life:	*HSTA VB - USAble Life Insurance*	❑	❑	**Not available to dependents**	

Note: The enrollment of HSTA VEBA members into the health and other benefit plans created as a result of the 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 the decision and reserves the right to move HSTA VEBA members into regular EUTF plans if that decision is overturned or modified.

Retiree's Name:

State and County Contributions: No person may be enrolled in any EUTF benefit plan as both a retiree/active employee and dependent, nor may children be enrolled by more than one retiree/active employee (dual enrollment). In addition, if you and your spouse/DP/CUP are both retirees/active employees, the employer's contribution cannot exceed a family plan contribution in accordance with Chapter 87A-33-36, Hawaii Revised Statutes. Both retirees/active employees are able to select EUTF Self-only plans, but not Self-only and 2-Party plans or Self-only and Family plans.

IV. DEPENDENT INFORMATION

Complete dependent information and indicate plan selection if adding/removing dependents.

Continue	Add	Delete	Last Name, First, Middle Initial	Birthdate	SSN	Relationship	Gender	Medical	Drug	Dental	Vision
❑	❑	❑						❑	❑	❑	❑
❑	❑	❑						❑	❑	❑	❑
❑	❑	❑						❑	❑	❑	❑

If dependents are ages 19 to 23 please submit certification from the school registrar or national clearinghouse indicating they are a full-time student. (Detailed elig bility information is available at http://eutf.hawaii.gov)

V. MEDICARE

Are you and/or any of your dependents eligible for Medicare Part B? ❑ Yes (Complete section below) ❑ No

Name:	Medicare Claim Number:
Name:	Medicare Claim Number:

State law requires that retirees and their covered dependents enroll in Medicare Part B when they become elig ble in order to be enrolled in HSTA VB retiree medical and/or prescription drug coverage, HRS Chapter 87A-23(4). Please submit a copy of your Medicare card.

VI. OTHER INSURANCE INFORMATION

If you or any of your dependents are covered under another non-EUTF health plan(s), provide data below.

Type of Plan: (i.e. medical, dental)	Name of the Plan: (i.e. HMSA, Quest)	Subscribers Name(s):

VII. 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 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 elected.

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. EUTF retains the right to terminate coverage in the event of non-payment, if payment is applicable. This form supersedes all forms and submissions 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 penalties for perjury.

Retiree Signature *Date*

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

EUTF
PO BOX 2121
Honolulu, HI 96805

Or you may hand deliver to:

EUTF
201 Merchant Street, Suite 1700
Honolulu, HI 96813

Customer Service Call Center

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

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