STATE OF HAWAII PREMIUM CONVERSION PLAN
ELECTION CHANGE FORM (Form PCP-2)

Premium Conversion Plan (PCP) is a voluntary benefit plan, administered by the State Department of Human Resources Development (DHRD) that allows employees to pay for their health benefit plan premiums on a pretax basis. Premium conversion plans are governed by Section 125 of the Internal Revenue Code (IRC). **Submit this form to your Human Resources Office within 90 days of a qualifying event. Changes/cancellations must be consistent with the "change of status" event indicated as defined by Section 125, IRC and shall become effective on a PROSPECTIVE basis from the "Employer's Receipt in Office date"**

Employee Information	Full Name (Last, First, Middle)	Last 4-digits of Social Security Number	Date of Qualifying Event
Please Check Benefit Plans Affected:	☐ Medical/Prescription Drug/Chiropractic Plan	☐ Vision Plan	☐ Dental Plan

☐ **I elect to CHANGE the amount of the PCP reduction of my pay from:**

☐ *From 2-party to* Family Enrollment	☐ *From* Family *to* 2-party or Self-Only Enrollment
☐ *From* Self-Only *to* 2-party or Family Enrollment	☐ *From* 2-party *to* Self-Only enrollment
o Open Enrollment o Birth or adoption o My Marriage o My eligible dependent (re-) joined my household o My dependent's loss of eligibility for coverage under a health benefits plan o My spouse's health benefits plan is significantly changed or terminated o My dependent(s) satisfies the eligibility requirements of the plan (e.g., full-time student, etc.) o Other (I have attached a written explanation)	o Open Enrollment o My Divorce/annulment of my marriage o Death of my dependent(s) o My dependent(s) no longer satisfies the eligibility requirements of the plan (e.g., attainment of age, loss of student status, marriage, etc.) o My spouse/dependent child becoming eligible for and electing coverage under other health benefits plan o Other (I have attached a written explanation)
☐ Change of health benefits plan insurance carrier because new residence is out of service area of my present carrier	
☐ Change to new employment classification where other component plans have become available or where my carrier's plan is not available	

☐ **I elect to PARTICIPATE in the Premium Conversion Plan due to:**

o Self-Only	o 2-Party	o Family Enrollment

o My being out-of-state during the entire Open Enrollment Period
o My return from a leave without pay status
o Birth of a child
o My loss of health benefits plan coverage because of the involuntary termination of my enrollment or my spouse's enrollment due to:
  - o Death
  - o Divorce/annulment of my marriage
  - o Eligibility/employment termination

☐ **I elect to TERMINATE my participation in the Premium Conversion Plan due to:**

o Open Enrollment
o My transfer to a non-eligible employment classification
o My loss of eligibility for coverage under a component plan
o I will be covered under my new second employer's health benefits plan or a new health benefits plan offered by my second employer
o My marriage. I will be covered under my spouse's employer's plan
o I will be covered as a dependent under my spouse's new employer's plan or retiree health benefits plan
o My spouse, who is also a State employee, changed his/her health plan enrollment to family coverage due to the birth/adoption of our child
o I will be placed on a leave without pay status
o Other (I have attached a written explanation)

I understand that I am making an election that is binding for the remainder of the plan year. I also understand that during this period I may not modify my reduction in pay unless (1) the plan is terminated, (2) there is an increase in the amount required employee contributions for the coverage which I have elected in conjunction with this current Election Change Form, (3) there is a change in my personal status that qualifies under the Internal Revenue Code.

Employee Signature_____ Date_____

Human Resources Office (HRO) Use Only

Department	Division/School	Bargaining Unit
Employer's Receipt in Office Date	PCP Effective Date	
Human Resources Officer (or employer designee) SIGNATURE	HRO phone/fax number	