EC-2 Enrollment Form Instructions

Enrollment Type

Select the event for which you are submitting the enrollment form. Mark the Retirement box if you're newly retired, Qualifying Event box if you are making changes outside of the Open Enrollment period, or the Open Enrollment box during the annual or limited open enrollment period. If submitting the enrollment form for a qualifying event, give a brief description of the event and input the date the qualifying event occurred.

I. Retiree Data

Complete all information about yourself and your spouse/partner.

II. Coverage Start Date

This section only needs to be completed if filing for adoption/placement for adoption, birth, marriage, domestic partner, guardianship or new eligible student, and you pay towards health plan benefits. Select one of the three choices for when your coverage and premium contributions will begin. (Option #1) Coverage starts on the event date. Premium contributions start 1st day of the pay period in which the event date occurs. (Option #2) Coverage and Contributions start 1st day of the first pay period following the event date. (Option #3) Coverage and Contributions start 1st day of the 2nd pay period following the event date. If no selection is made, Option 1 will be used, and you will be responsible for the full premium in said pay period.

III. Plan Selection

Mark all plans you wish to be enrolled in. You may only enroll in ONE medical plan. If you select Kaiser, your medical selection will include Kaiser Prescription drug coverage. If you select HMSA and wish to enroll in prescription drug coverage, you must select the CVS Caremark prescription drug plan (if you do not make a selection you will not have any prescription drug coverage). If you wish to dis-enroll from plans, mark the "Cancel/Waive" box. If no selection is made, EUTF will assume no changes are being made.

IV. Dependent Information

Complete dependent information and indicate plan selection if adding or removing dependents. If you are adding/removing more than three dependents and additional rows are needed, please attach another sheet to your enrollment form. If this is your first time enrolling dependents in EUTF plans, please submit required proof documents including a marriage certificate if adding your spouse or partner and a birth certificate and guardianship or adoption decree (if applicable) if adding a child(ren). If a dependent child is age 19 to 24, unmarried and covered under your medical, drug, dental and/or vision plans, please submit certification from the school registrar or national clearinghouse indicating they are a full-time student. Required proof documents must be submitted to the EUTF within 45 days of the event date. Social security numbers are required for all newly added dependents. Detailed eligibility information including required proof documents for other life-events are available online at eutf.hawaii.gov.

V. Medicare

If you and/or your dependent(s) are eligible to enroll in Medicare Part B, complete the name and Medicare Claim Number of the individuals enrolled. Additionally, you must submit proof of Medicare Part B enrollment to the EUTF in order to be enrolled in EUTF retiree medical and/or prescription drug coverage. Submit a copy of your Medicare card (indicating enrollment in Medicare Part B), letter from the Social Security Administration indicating your Medicare Part B premium, and EUTF Direct Deposit Agreement form. Failure to comply may result in loss of EUTF medical and/or prescription drug coverage.

VI. Other Insurance Information

If you or your dependents are covered under another health plan, you are required to complete this section. The information that you provide does not determine how your benefits are coordinated. Coordination of Benefits rules are determined by the health benefit plans and follow the guidelines of the National Association of Insurance Commissioner (www.naic.org).

VII. Retiree Signature

Read, sign and date the form.

Submit your EC-2 form to the EUTF office. Please see address printed on the bottom of page 2 of the enrollment form. To ensure proper processing, all required fields must be complete and proper documentation submitted timely.

Hawaii Employer-Union Health Benefits Trust Fund

EC-2 RETIREE HEALTH BENEFITS ENROLLMENT 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: ❑ Male ❑ Female Birthdate: __________

Marriage Date: ___/___/___

Home Phone: (__________ Cell Phone: (__________ Email: __________

Spouse/Partner Name: __________ SSN: __________ Birthdate: ___/___/___

Note:If you will be adding your spouse or partner to your health plans, you must also indicate this information under the "Dependent Information" section

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:	*HMSA PPO-90/10 Medical (No Prescription Drug Coverage)*	❑	❑	❑	❑
Choose ONE	*Kaiser HMO Medical (Includes Kaiser Prescription Drug)*	❑	❑	❑	❑
Prescription Drug:	*CVS Caremark Prescription Drug (Not a valid selection with Kaiser)*	❑	❑	❑	❑
Dental:	*Hawaii Dental Service*	❑	❑	❑	❑
Vision:	*Vision Service Plan*	❑	❑	❑	❑
Life:	*Securian Life Insurance*	❑	❑	***Not available to dependents***	

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/partner 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. However, both retirees/active employees are able to select EUTF Self-only plans.

IV. DEPENDENT INFORMATION

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

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

If dependents are ages 19 to 24 please submit certification from the school registrar or national clearinghouse indicating they are a full-time student. (Detailed eligibility information is available at https://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 eligible in order to be enrolled in EUTF/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 to:

EUTF
201 Merchant Street, Suite 1700
Honolulu, HI 96813

Customer Service Call Center

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