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 (HRO) designee or Department of Education-Employee Benefits Unit (DOE-EBU) within 90 calendar 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”

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

☐ 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

☐ Open Enrollment (non-EUTF, e.g. spouse’s employer’s open enrollment)
☐ Birth, adoption, or placement for adoption of a child
☐ My Marriage
☐ My eligible dependent (re-) joined my household
☐ My dependent’s loss of eligibility for coverage under a health benefits plan
☐ My spouse’s health benefits plan is significantly changed or terminated
☐ My dependent(s) satisfies the eligibility requirements of the plan (e.g., full-time student, etc.)

Other IRS Qualifying Reason (I have attached a written explanation) Other IRS Qualifying reason (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:

☐ Self-Only ☐ 2-Party ☐ Family Enrollment

☐ My being out-of-state during the entire Open Enrollment Period
☐ My return from a leave without pay status
☐ Birth, adoption, or placement for adoption of a child
☐ My loss of health benefits plan coverage because of the involuntary termination of my enrollment or my spouse’s enrollment due to:

☐ Death
☐ Divorce/annulment of my marriage
☐ Eligibility/employment termination

Other IRS Qualifying Reason (I have attached a written explanation)

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

☐ Open Enrollment (non-EUTF, e.g. spouse’s employer’s open enrollment)
☐ My transfer to a non-eligible employment classification
☐ My loss of eligibility for coverage under a component plan
☐ I will be covered under my new second employer’s health benefits plan or a new health benefits plan offered by my second employer
☐ My marriage. I will be covered under my spouse’s employer’s plan
☐ I will be covered as a dependent under my spouse's new employer’s plan or retiree health benefits plan
☐ 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
☐ I will be placed on a leave without pay status

Other IRS Qualifying Reason (I have attached a written explanation)

I have read the PCP materials, understand the limitations and qualifications of the PCP program, and agree to abide by the terms and conditions of the Plan. 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 ____________

HRO designee or DOE-EBU Use Only

<table>
<thead>
<tr>
<th>Department</th>
<th>Division/School</th>
<th>Bargaining Unit</th>
<th>HRO phone/fax number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer’s Receipt in Office Date</td>
<td>PCP Effective Date</td>
<td></td>
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</tr>
</tbody>
</table>

HRO or DOE-EBU (or employer designee) PRINT Name HRO or DOE-EBU (or employer designee) SIGNATURE

PCP-2 Rev. January 2021