EC-2 Enrollment Form Instructions

Retiree Data

Select the event for which you are submitting the enrollment form. Mark the Retirement box if you're newly retired, the 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 the date the qualifying event occurred. Complete all information about yourself and your spouse/partner. The race and ethnicity section is optional. Please refer to the back page of these instructions for more information on completing the race and ethnicity section.

Coverage Start Date

This section only needs to be completed if filing for adoption, placement for adoption, birth, marriage, domestic partner, guardianship, or newly 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 second 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.

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 Permanente Drug coverage. If you select HMSA or Humana 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.

Note: If you are currently enrolled in the Kaiser HMO Medical Plan and have assigned your Medicare Benefits to KP and either select the "Cancel/Waive" box or enroll in either the HMSA PPO 90/10 Medical plan or the CVS Caremark Prescription Drug plan, you are also confirming your intent to dis-enroll from the Kaiser Permanente Senior Advantage plan as well.

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 marriage certificate if adding your spouse/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.

Medicare

If you and/or your dependent(s) (spouse/partner/disabled child) 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.

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).

Retiree/Dependent Signature

Read, sign and date the form.

Note: Dependent signature(s) and Date(s) are required if the dependent is enrolling or disenrolling in/from the Humana, Kaiser HMO Coverage or CVS/SilverScript plans. Failure for both the retiree and dependent(s) to sign when applicable, may result in continued Medicare enrollment with Humana, Kaiser Permanente or CVS/SilverScript.

Submit your EC-2 form and required supporting documents to the EUTF office. Please see address at bottom of page 2 of the enrollment form. To ensure proper processing, all required fields must be complete and proper documentation submitted timely. Required supporting documents are due within 45 days of the qualifying event date, with exception to birth (180 days) and open enrollment.

Optional Race and Ethnicity Questionnaire

You may choose to provide your race and ethnicity of yourself and your covered dependents under the Retiree Data and Dependent sections of the EC-2 form. Participation in this questionnaire is voluntary and will not affect your enrollment eligibility in EUTF health plans. Please refer to the options below.

Are you of Hispanic, Latino/a, or Spanish origin?

- No, not of Hispanic, Latino/a, or Spanish origin
- Yes, Mexican, Mexican American, Chicano/a
- Yes, Puerto Rican
- Yes, Cuban
- Yes, of another Hispanic, Latino/a, or Spanish origin
- Choose not to answer

What is your race?

- American Indian or Alaska Native
- Black or African American
- White
- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Choose not to answer

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose, and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) “Medicare Advantage Prescription Drug (MARx)”, System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Hawaii Employer-Union Health Benefits Trust Fund

EUTF RETIREES
EC-2 HEALTH BENEFITS ENROLLMENT FORM

RETIREE DATA

Complete each section thoroughly. Please print clearly

	Retirement	Qualifying Event	Open Enrollment
Enrollment Type (Must check one box):	☐	☐	☐

Retirement or Qualifying Event Date: _____ **Qualifying Event Description:** _____

Full Name: _____ Social Security No.: _____

Last Name, First Name, Middle Initial

Mailing Address: _____
Street Name Apt No.

_____
City, State Zip Code

Residence Address: _____
Street Name Apt No.

_____
City, State Zip Code

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner Gender: ☐ Male ☐ Female ☐ Gender X

Marriage Date: _____ Birthdate: _____

Former Employer Department/Division: _____ Bargaining Unit: _____

Home Phone: _____ Cell Phone: _____ Email: _____

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

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

Optional Race and Ethnicity Disclosure

Are you of Hispanic, Latino/a, or Spanish origin? _____ What is your race? _____

COVERAGE START DATE

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

☐ Coverage starts day of the event and 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 16th of the month)

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

PLAN SELECTION

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

Medical (select one)				
HMSA PPO 90/10 Medical ** (does not include Prescription Drug)	☐ Cancel/Waive	☐ Self	☐ Two-Party	☐ Family
Kaiser HMO Medical ** (includes Kaiser Prescription Drug)	☐ Cancel/Waive	☐ Self	☐ Two-Party	☐ Family
Humana Medicare Advantage (Medicare A & B required)	☐ Cancel/Waive	☐ Self	☐ Two-Party	☐ Family
Prescription Drug				
CVS Caremark Prescription Drug ** (not a valid selection with Kaiser)	☐ Cancel/Waive	☐ Self	☐ Two-Party	☐ Family
Dental				
Hawaii Dental Service	☐ Cancel/Waive	☐ Self	☐ Two-Party	☐ Family
Vision				
Vision Service Plan	☐ Cancel/Waive	☐ Self	☐ Two-Party	☐ Family
Life				
Securian Life Insurance	☐ Cancel/Waive	☐ Self		

*** **NOTE:** If you are currently enrolled in the Kaiser HMO Medical Plan and have assigned your Medicare Benefits to KP and either select the "Cancel/Waive" box or enroll in either the HMSA PPO 90/10 Medical Plan or the CVS Caremark Prescription Drug Plan, you are also confirming your intent to disenroll from the Kaiser Permanente Senior Advantage Plan as well.*

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 situations where you and your spouse/partner are both retiree/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. Lastly, 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 eutf.hawaii.gov)*

DEPENDENT INFORMATION

Complete dependent information (including spouse/partner/disabled child) and indicate plan selection if adding/removing dependents

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

Optional Race and Ethnicity Disclosure (Dependents)

Are any of your dependents of Hispanic, Latino/a, or Spanish origin? _____

What is your dependent's race? _____

MEDICARE

Are you and/or any of your dependents eligible for Medicare Part A & B? ☐ Yes (complete section below) ☐ No

Name	Medicare Claim Number	Medicare Part A Effective Date	Medicare Part B Effective Date

State law requires that retirees and their 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.

Kaiser Members: Kaiser Permanente is a Medicare Advantage plan. Medicare eligible members residing in the Hawaii Senior Advantage Service Area are required to enroll in the EUTF Senior Advantage Plan. I understand that my signature confirms enrollment in the EUTF Senior Advantage Plan and this will automatically end my enrollment in another Medicare plan.

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)	Subscriber's Name

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 or 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*

_____ _____

*Dependent (Spouse/Partner) Signature *** *Date*

_____ _____

*Dependent (Disabled Child) Signature *** *Date*

Various health plan providers offer services to EUTF members. Some of these services are at no charge to either the EUTF or the State of Hawaii. These services which are offered at no charge are not a part of the health benefits package provided to you by the State of Hawaii and its municipalities by virtue of your employment or membership in the EUTF. These services offered at no charge are listed in the EUTF reference guides, [and] are provided only as [a] pilot programs and are subject to modification or termination at any time by the service provider, EUTF, and/or the State of Hawaii at their sole discretion. The State and EUTF expressly do not promise, do not warrant, do not guarantee, and make no representation that these services offered at no charge will be available to EUTF active or retired employees or their beneficiaries at any time in the future or in any form or manner.

***** Note:*** *Dependent Signature(s) and Date(s) are required if the dependent is enrolling or disenrolling in/from the Humana, Kaiser HMO Coverage or CVS/SilverScript plans. Failure for both the retiree and dependent(s) to sign when applicable, may result in continued Medicare enrollment with Humana, Kaiser Permanente, or CVS/SilverScript.*

Please submit your signed EC-2 form to:
EUTF
201 Merchant Street, Suite 1700
Honolulu, HI 96813

Member Services:
Oahu: (808) 586-7390
Toll-free: (800) 295-0089