EC-1H Enrollment Form Instructions

Use of this form is for members currently enrolled in the HSTA VB plans. If you are not currently enrolled in the HSTA VB plans, please use the EC-1 form. Submit the completed EC-1H form to the DOE-EBU office, or your Charter School Personnel Office for verification, signature, and routing to the EUTF within 45 days (180 days for newborns) of the event date.

Employee Data

Select the Enrollment Type for which you are submitting the Enrollment form. Mark the Qualifying Event box if you are making a change 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. Common qualifying events include: **Acquisition of Coverage, Adoption, Birth, Civil Union Partner, Court Order, Death, Divorce, Domestic Partnership, Foster Child, Guardianship, Ineligible Student, Approved Leave of Absence Without Pay (LWOP), Legal Separation, Loss of Coverage, Marriage, Moving Out of the Coverage Area, Newly Eligible Employee, Newly Eligible Student, Reinstatement of Employment, or Termination of Domestic Partnership**. Complete all information about yourself and your spouse/partner.

Coverage Start Date

Carefully consider when you would like your health plans and premium deductions to begin and check the appropriate box. You can select one of the following:

- (Option #1) Coverage starts on the date of hire or event date. Premium contributions start 1st day of the pay period in which the date of hire or event date occurs.
- (Option #2) Coverage and contributions start 1st day of the first pay period following the date of hire or event date.
- (Option #3) Coverage and contributions start 1st day of the second pay period following the date of hire or 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. Loss of Coverage and Acquisition of Coverage must start on event date (Option #1).

Plan Selection

Mark all plans you wish to be enrolled in. You can choose one medical/prescription drug plan, one dental plan, and one vision plan. The prescription drug plan is bundled with the medical plan and will depend on the medical plan you select. If you do not want any plan coverage, mark the "Cancel/Waive" box. If no selection is made and you currently have coverage, EUTF will assume no changes are being made.

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 on more than one retiree/active employee plan (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.

For State Employees Only: The Premium Conversion Plan (PCP) is a voluntary benefit plan, administered by the Department of Human Resources Development (DHRD) that allows you to purchase your health benefit plans on a pre-tax basis and is offered pursuant to Section 125 of the Internal Revenue Code. By enrolling in the PCP, you are allowing deductions for your health plan premium contributions from your gross pay before Federal, State, and Social Security taxes are withheld. Since there may be tax implications, please visit the DHRD website at dhrd.hawaii.gov for more information. State employees making mid-plan year elections should inquire with their Human Resources Office or DHRD on completing a PCP-2 form. Enrollment in the PCP is not automatic. Mark the "Enroll" or "Cancel/Waive" box. If no selection is made (i.e., left blank), new enrollments shall default to "Not Enrolled" and existing PCP enrollments shall continue.

Dependent Information

Complete dependent information and indicate plan selection if adding, removing, or continuing coverage for dependents. If you are adding or removing more than five 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 23, unmarried and covered under your 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.

Use the following Relationship codes:

SP = Spouse	CH = Child	SC = Step Child
DP = Domestic Partner	DPCH = Domestic Partner's Child	GC = Guardianship or Foster Child
CU = Civil Union Partner	CUCH = Civil Union Partner's Child	DC = Disabled Child

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).

Employee Signature

Read, sign and date the form. Submit your EC-1H form to DOE-EBU, PO Box 2360, Honolulu, HI 96804. To ensure proper processing, all required fields must be completed and proper documentation submitted timely.

Hawaii Employer-Union Health Benefits Trust Fund

Submit this form to:

DOE-EBU
PO Box 2360
Honolulu, HI 96804

HSTA VB ACTIVE EMPLOYEE
EC-1H HEALTH BENEFITS ENROLLMENT FORM

Bargaining Unit 05 (Formerly Under HSTA VEBA

EMPLOYEE DATA

Complete each section thoroughly. Please print clearly

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

Qualifying Event Date: _____ **Qualifying Event Description:** _____

Full Name: _____ Social Security No.: _____
Last Name, First Name, Middle Initial

Mailing Address: _____
Street Address
_____
City, State Zip Code

Residence Address: _____
Street Address
_____
City, State Zip Code

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

Marriage Date: _____

Home Phone: _____ Cell Phone: _____ Business Email: _____

Personal 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.

COVERAGE START DATE

DO NOT SKIP THIS SECTION. Read the "EC-1H Enrollment Form Instructions" and complete this section before moving on. Select one.

☐ (Option #1) 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 OPTION IS SELECTED, OPTION #1 WILL BE USED)**

☐ (Option #2) Coverage and premium contributions start 1st day of the first pay period following event (1st or 16th of the month)

☐ (Option #3) Coverage and premium contributions start 1st day of the second pay period following event (1st or 16th of the month)

PLAN SELECTION EFFECTIVE 7/1/24 THROUGH 6/30/25

Medical, Chiro, Prescription Drug, and Vision (select one)				
HMSA PPO 90/10 Medical, Chiro, CVS Prescription Drug, and VSP Vision Monthly Employee Premium	☐ Cancel/Waive	☐ Self $433.90	☐ Two-Party $1,051.82	☐ Family $1,340.96
HMSA PPO 80/20 Medical, Chiro CVS Prescription Drug, and VSP Vision Monthly Employee Premium	☐ Cancel/Waive	☐ Self $306.00	☐ Two-Party $741.52	☐ Family $945.00
Kaiser HMO Comprehensive Medical, Chiro, Prescription Drug, and VSP Vision Monthly Employee Premium	☐ Cancel/Waive	☐ Self $270.40	☐ Two-Party $657.74	☐ Family $840.76
Dental (select one)				
Hawaii Dental Service Monthly Employee Premium	☐ Cancel/Waive	☐ Self $16.18	☐ Two-Party $32.38	☐ Family $53.26
Supplemental Dental - Hawaii Dental Service Monthly Employee Premium	☐ Cancel/Waive	☐ Self $7.56	☐ Two-Party $15.10	☐ Family $22.66
Vision				
Vision Service Plan Monthly Employee Premium	☐ Cancel/Waive	☐ Self $1.68	☐ Two-Party $3.14	☐ Family $4.10
Life				
Securian Life Insurance	☐ Cancel/Waive	☐ Self	No cost to employee	
Premium Conversion Plan* (State Employees only)	☐ Cancel/Waive	☐ Enroll		

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

***State Employees Only:** The Premium Conversion Plan (PCP) is a voluntary benefit plan that allows you to purchase your health benefit plans on a pre-tax basis and is offered pursuant to Section 125 of the Internal Revenue Code. Refer to the EC-1H instructional page for more information. Enrollment in the PCP is not automatic. If no selection is made (i.e., left blank), the PCP election shall default to "Not Enrolled".*

Employee'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 retiree/active employees, the employer's contribution cannot exceed a family plan contribution in accordance with Chapter 87A-33-36, Hawaii Revised Statutes.*

DEPENDENT INFORMATION

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

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

If dependents are ages 19 to 23 and covered under your dental and/or vision plans, please submit certification from the school registrar or national clearinghouse indicating they are a full-time student. Detailed eligibility information is available online at eutf.hawaii.gov

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

EMPLOYEE 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 understand that if I waive coverage for myself or my dependents that I/they cannot enroll for benefits in EUTF's Plan unless eligible at the next Open Enrollment period or earlier, if there is a mid-year Special Enrollment event such as loss of coverage, marriage, birth, or adoption. 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. I authorize my employer or finance officer to make the pre-tax or after-tax deductions, adjustments, or cancellations from my salary, wages, or other compensation for the monthly employee contribution in accordance with applicable laws, rules, and regulations.

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. I agree to immediately notify the Fund in writing of any changes that would result in the loss or change of eligibility of my or any of my dependent-beneficiary's benefits. I understand that the Fund reserves the right to terminate benefits and to seek recovery of any overpayment of benefits resulting from my failure to provide written notice within forty-five (45) days of the event that caused the change or ineligibility. 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.

_____ _____

Employee Signature *Date*

---------- **Official Use Only** ----------

Department ID #	**Department**	**School/Office**	**Bargaining Unit**

Date Received in DOE-EBU/Charter School Office	**DOE-EBU/Charter School Phone Number**	**DOE-EBU/Charter School Fax Number**

DOE-EBU/Charter School (or employer designee) Printed Name	**Date of DOE-EBU/Charter School (or employer designee) Signature**

DOE-EBU/Charter School (or employer designee) Signature

By signing this EC-1H form, I am attesting that this employee is eligible for EUTF benefits as per Chapter 87A, Hawaii Revised Statutes.

Comments: