EC-1 Enrollment Form Instructions

Employee Data

Select the Enrollment Type for which you are submitting the Enrollment form. Mark the New Hire box if you're newly hired, 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: **Disenroll Due to Enrollment in Other Coverage, Adoption, Birth, Civil Union Partner, Court Order, Death, Divorce, Domestic Partnership, Guardianship, Approved Leave of Absence Without Pay (LWOP), Legal Separation, Loss of Coverage, Marriage, Moving Out of the Coverage Area, New Hire, Newly Eligible Employee, 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 Disenroll Due to Enrollment in Other 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 and Maui County Employees Only: 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. For State employees, PCP is administered by the Department of Human Resources Development (DHRD). For County of Maui employees, PCP is administered by the County of Maui. 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 or County of Maui intranet 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 (the PCP-2 form is not required of County of Maui employees). 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.

For All Other County Employees Only: Premium Conversion Plan (PCP) is administered by the Budget and Fiscal Services Department. Please contact your Department Personnel Office for more information on available options.

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). 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-1 form to your department human resource office or enrollment designee for verification, signature, and routing to EUTF within 45 days (180 days for newborns) of the event date. DOE employees please submit your EC-1 form to the address printed on the top right-hand corner of the enrollment form. To ensure proper processing, all required fields must be completed and proper documentation submitted timely.

Hawaii Employer-Union Health Benefits Trust Fund

EUTF ACTIVE EMPLOYEE
EC-1 HEALTH BENEFITS ENROLLMENT FORM

Bargaining Units 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 12, 13 only

Submit this form to your personnel office

DOE employees submit to:
DOE-EBU
PO Box 2360
Honolulu, HI 96804

EMPLOYEE DATA

Complete each section thoroughly. Please print clearly

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

New Hire or Qualifying Event Date: _____ **Qualifying Event Description:** _____

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

Mailing Address: _____ Residence Address: _____
Street Address. *Street Address*

_____ _____
City, State Zip Code *City, State Zip Code*

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

Marriage Date: _____ Birthdate: _____

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.

COVERAGE START DATE

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

☐ (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 7/1/26 THROUGH 6/30/27

Medical, Chiro, and Prescription Drug (select one)				
HMSA PPO 75/25 Medical, Chiro and CVS Prescription Drug **Monthly Employee Premium**	☐ Cancel/ Waive	☐ Self **$63.56/mo**	☐ Two-Party **$154.36/mo**	☐ Family **$196.76/mo**
HMSA PPO 80/20 Medical, Chiro and CVS Prescription Drug **Monthly Employee Premium**	☐ Cancel/ Waive	☐ Self **$392.52/mo**	☐ Two-Party **$953.38/mo**	☐ Family **$1,215.46/mo**
Kaiser Permanente HMO Standard Medical, Chiro and Prescription Drug **Monthly Employee Premium**	☐ Cancel/ Waive	☐ Self **$60.66/mo**	☐ Two-Party **$147.38/mo**	☐ Family **$188.00/mo**
Kaiser Permanente HMO Comprehensive Medical, Chiro and Prescription Drug **Monthly Employee Premium**	☐ Cancel/ Waive	☐ Self **$298.14/mo**	☐ Two-Party **$725.08/mo**	☐ Family **$926.22/mo**
Verdegard Supplemental Medical and Prescription Drug (Must have coverage under a non-EUTF health plan to be eligible for Supplemental)	☐ Cancel/ Waive	☐ Self **$14.58/mo**	☐ Two-Party **$25.78/mo**	☐ Family **$27.90/mo**
Dental				
Hawaii Dental Service Monthly Employee Premium	☐ Cancel/ Waive	☐ Self $17.30/mo	☐ Two-Party $34.58/mo	☐ Family $51.86/mo
Vision				
Vision Service Plan Monthly Employee Premium	☐ Cancel/ Waive	☐ Self $1.68/mo	☐ Two-Party $3.14/mo	☐ Family $4.10/mo
Life				
Securian Life Insurance	☐ Cancel/ Waive	☐ Self	No cost to employee	
Premium Conversion Plan* (State and Maui County Employees only)	☐ Cancel/ Waive	☐ Enroll		

**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-1 instructional page for more information. 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.*

***HMSA PPO 90/10** is closed to new subscribers effective July 1, 2026 and **HMSA HMO** is closed to new subscribers effective July 1, 2025. Employees currently enrolled in the HMSA PPO 90/10 and HMSA HMO plan may continue their coverage and can make qualified changes to their enrollment by accessing the member portal at eutfbenefits.hawaii.gov. An employee that leaves their HMSA PPO 90/10 or HMSA HMO plan may not re-enroll.*

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
☐	☐	☐						☐	☐	☐
☐	☐	☐						☐	☐	☐
☐	☐	☐						☐	☐	☐
☐	☐	☐						☐	☐	☐
☐	☐	☐						☐	☐	☐

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**	**Division/School**	**Bargaining Unit**
Date Received in Office	**DPO Phone Number**	**DPO Fax Number**	
DPO (or employer designee) Printed Name		**Date of DPO (or employer designee) Signature**	
DPO (or employer designee) Signature By signing this EC-1 form, I am attesting that this employee is eligible for EUTF benefits as per Chapter 87A, Hawaii Revised Statutes.			
Comments:			