

NEIL ABERCROMBIE  
GOVERNOR



**STATE OF HAWAII**  
**HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND**

P.O. BOX 2121  
HONOLULU, HAWAII 96805-2121  
Oahu (808) 586-7390  
Toll Free 1(800) 295-0089  
www.eutf.hawaii.gov

**BOARD OF TRUSTEES**  
GEORGE KAHOOHANOHANO, CHAIRPERSON  
DEREK MIZUNO, VICE-CHAIRPERSON  
DEAN K. HIRATA, SECRETARY-TREASURER  
LORETTA FUDDY  
AUDREY HIDANO  
EVERETT KANESHIGE  
BARBARA KRIEG  
KAROLYN MOSSMAN  
CELESTE Y.K. NIP  
CLIFFORD UWAINA

**ADMINISTRATOR**  
BARBARA CORIELL

November 22, 2011

TO: COBRA Participants of the State and Counties

FROM: Barbara Coriell, Administrator 

SUBJECT: 2012 Health Plan Premium Rates and Open Enrollment for COBRA Participants

The Trustees of the Hawaii Employer-Union Health Benefits Trust Fund (EUTF) approved health plan premium rates for 2012. These premium rates and certain changes will be effective January 1, 2012. In other circumstances rate changes take effect March 1, 2012 (Attachments #4 and #5).

An open enrollment period will be conducted from **November 23, 2011 through December 14, 2011** to provide you with an opportunity to make changes to your COBRA health plan enrollments if you wish to do so. Plan changes properly submitted during this open enrollment period will be effective January 1, 2012. Your completed form must be postmarked to EUTF **on or before December 14, 2011**. Please note that if you do **NOT** want to make changes you do **NOT** need to complete the COBRA Open Enrollment Form.

Also note that the HMA 90/10 PPO will be insured with HMSA effective January 1, 2012. The plan (coverage) will remain the same but the administrator is changing from HMA to HMSA. If you are enrolled in the HMA 90/10 plan and want to keep that plan, you do **not** need to fill out an enrollment form. Your enrollment will be automatically transferred from HMA to HMSA.

Current rates for EUTF COBRA participants are applicable until February 28, 2012. All other COBRA rates changes are effective January 1, 2012.

Attachment #1 is a chart of the current premium rates for EUTF COBRA Actives - all Bargaining Units except 12.

Attachment #2 is a chart of the current premium rates for EUTF COBRA Actives in Bargaining Unit 12.

Attachment #3 is a chart of the HSTA VB COBRA Active Rates effective January 1, 2012.

Attachment #4 is a chart of the EUTF COBRA Active Rates for all Bargaining Units except 12 effective March 1, 2012.

Attachment #5 is a chart of the EUTF COBRA Active Rates for Bargaining Units 12 effective March 1, 2012.

Note: Separate invoices will be billed by each carrier selected.

Enclosed you will find the edited Active Employees Reference Guide for January 1, 2012 – June 30, 2013 as well as the COBRA Open Enrollment Forms.

***Can I change plans now?***

Yes. Please fill out and submit the EUTF COBRA Election Form dated November 2011.

***If I do not complete a Continuation of Coverage COBRA Election Form during the COBRA open enrollment period, will my health benefits terminate?***

You do not need to complete a COBRA Election Form to continue your current coverage. However, if you did not make payment directly to the carriers (see page 3) by the first of the month, your coverage will be terminated. If you did make payment by the first of the month, your COBRA health benefits will continue.

***Will EUTF be conducting any open enrollment sessions that we can attend?***

No.

***I want to make a change and if I forget to check any box next to the various choices, what happens?***

EUTF will assume you do not want (waive) that coverage.

***If I do not want to make changes, do I still need to complete a COBRA Enrollment Form?***

No.

***If I want to make a change during the open enrollment, where do I send my completed COBRA Form?***

Your completed form must be postmarked to EUTF on or before **December 14, 2011**.

Mail your completed forms to EUTF. Our mailing address is:

Hawaii Employer-Union Health Benefits Trust Fund  
ATTN: COBRA Unit  
P.O. Box 2121  
Honolulu, HI 96815-2121

Memorandum to COBRA Participants

November 22, 2011

Subject: 2012 Health Plan Premium Rates and Open Enrollment for COBRA Participants

Page 3

*If I have questions, who can I contact?*

We suggest you visit the EUTF website at [eutf.hawaii.gov](http://eutf.hawaii.gov) first to see if the information you need is available there. Click on the following links that may be pertinent:

- New COBRA Guidelines
- Links to Carrier Web Sites

If you still have questions, we prefer you email us your questions at: [eutf@hawaii.gov](mailto:eutf@hawaii.gov). In the subject line type: “URGENT – COBRA INQUIRY”. EUTF can answer your questions about eligibility, status of your enrollment, required supporting documents, and timing of submission of forms. However, if you have questions related to the **benefits** in any plan, we recommend you contact the applicable insurance carrier. Their contact information is:

- **ChiroPlan:**  
Honolulu (808) 621-4744, Neighbor Islands 1 (800) 414-8445  
711 Kilani Avenue, Suite 3, Wahiawa, HI 96786
- **Hawaii Dental Service (HDS):**  
(808) 529-9310, Toll-free 1 (866) 702-3883  
700 Bishop Street Suite 700, Honolulu, HI 96813
- **Hawaii Medical Service Association (HMSA):**  
Oahu (808) 948-6499, Toll-free 1 (800) 766-4672  
P.O. Box 860, Attn: Membership Services Dept., Honolulu, HI 96808-0860
- **Kaiser Permanente (Kaiser):**  
(808) 432-5955, Toll-free 1 (800) 966-5955  
711 Kapiolani Boulevard, Honolulu, HI 96813
- **informedRx [billing handled by ARM Ltd.]:**  
Toll-free 1 (866) 533-6977  
ARM Ltd., 171 West Wing Street #210, Arlington Heights, IL 60005
- **Vision Service Plan (VSP):**  
Honolulu (808) 532-1600, Toll-free 1 (800) 522-5162  
P.O. Box 997100, Sacramento, CA 95899

**HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND  
 COBRA ACTIVE EMPLOYEES  
 ALL BU'S EXCEPT BU12  
 HSTA VEBA ACTIVE EMPLOYEES WHO OPT TO TRANSFER TO EUTF PLANS (BU05,45)  
 BU 05, 45 EMPLOYEES HIRED ON OR AFTER JANUARY 1, 2011**

**EFFECTIVE MARCH 1, 2011**

<b>Benefit Plan</b>	<b>Type of Enrollment</b>	<b>Total COBRA Premium</b>
<b>MEDICAL PLANS</b>		
<b>EUTF PPO (HMA) - 90/10 Plan</b>	Self	\$318.95
	Two-Party	\$774.85
	Family	\$988.79
<b>EUTF PPO (HMSA) - 80/20 Plan</b>	Self	\$308.53
	Two-Party	\$749.53
	Family	\$956.50
<b>EUTF Prescription Drug (informedRx)</b>	Self	\$72.23
	Two-Party	\$175.40
	Family	\$223.93
<b>EUTF HMO (HMSA) Prescription Drug</b>	Self	\$433.19
	Two-Party	\$1,052.25
	Family	\$1,342.81
<b>Kaiser Comprehensive Prescription Drug</b>	Self	\$384.58
	Two-Party	\$934.40
	Family	\$1,192.01
<b>Kaiser Basic Prescription Drug</b>	Self	\$324.73
	Two-Party	\$789.03
	Family	\$1,006.58
<b>EUTF Supplemental (HMSA)</b>	Self	\$155.67
	Two-Party	\$378.64
	Family	\$483.34
<b>Royal State Supplemental Prescription Drug</b>	Self	\$40.12
	Two-Party	\$100.30
	Family	\$111.63
<b>EUTF High Deductible Health Plan (HMSA) Prescription Drug</b>	Self	\$294.42
	Two-Party	\$715.53
	Family	\$913.20
<b>DENTAL PLAN</b>		
<b>HDS Dental</b>	Self	\$32.64
	Two-Party	\$65.24
	Family	\$107.51
<b>VISION PLAN</b>		
<b>VSP Vision</b>	Self	\$6.10
	Two-Party	\$11.28
	Family	\$14.74
<b>CHIROPRACTIC</b>		
<b>RSN Chiropractic</b>	Self	\$1.46
	Two-Party	\$2.93
	Family	\$3.10

Attachment #1

**HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND  
 COBRA ACTIVE EMPLOYEES  
 BU12  
 EFFECTIVE MARCH 1, 2011**

<b>Benefit Plan</b>	<b>Type of Enrollment</b>	<b>Total COBRA Premium</b>
<b>MEDICAL PLANS</b>		
<b>EUTF PPO (HMA) - 90/10 Plan</b>	Self	\$284.32
	Two-Party	\$711.65
	Family	\$923.26
<b>EUTF PPO (HMSA) - 80/20 Plan</b>	Self	\$275.06
	Two-Party	\$688.40
	Family	\$893.12
<b>EUTF Prescription Drug (informedRx)</b>	Self	\$48.90
	Two-Party	\$122.26
	Family	\$158.63
<b>EUTF HMO (HMSA) Prescription Drug</b>	Self	\$377.93
	Two-Party	\$945.95
	Family	\$1,227.20
<b>Kaiser Comprehensive Prescription Drug</b>	Self	\$316.49
	Two-Party	\$791.07
	Family	\$1,025.22
<b>Kaiser Basic Prescription Drug</b>	Self	\$267.28
	Two-Party	\$668.10
	Family	\$865.82
<b>EUTF Supplemental (HMSA)</b>	Self	\$147.98
	Two-Party	\$373.32
	Family	\$491.76
<b>Royal State Supplemental Prescription Drug</b>	Self	\$40.12
	Two-Party	\$100.30
	Family	\$111.63
<b>EUTF High Deductible Health Plan (HMSA) Prescription Drug</b>	Self	\$267.96
	Two-Party	\$671.61
	Family	\$872.90
<b>DENTAL PLAN</b>		
<b>HDS Dental</b>	Self	\$32.64
	Two-Party	\$65.24
	Family	\$107.51
<b>VISION PLAN</b>		
<b>VSP Vision</b>	Self	\$6.10
	Two-Party	\$11.28
	Family	\$14.74
<b>CHIROPRACTIC</b>		
<b>RSN Chiropractic</b>	Self	\$1.46
	Two-Party	\$2.93
	Family	\$3.10

Attachment #2

**HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND  
FOR COBRA ACTIVE EMPLOYEES BU 05, 45 FORMERLY UNDER THE HSTA VEBA  
HSTA VB COBRA ACTIVE RATES  
EFFECTIVE JANUARY 1, 2012**

<b>Benefit Plan</b>	<b>Type of Enrollment</b>	<b>Total COBRA Premium</b>
<b>MEDICAL PLANS</b>		
PPO - 90/10 - HMSA	Self	\$413.51
	Two-Party	\$1,003.50
	Family	\$1,279.79
PPO - 80/20 - HMSA	Self	\$262.32
	Two-Party	\$636.62
	Family	\$811.90
**Prescription Drug	Self	\$61.16
	Two-Party	\$148.60
	Family	\$189.35
HMO - Kaiser Comprehensive Kaiser Prescription drug	Self	\$386.34
	Two-Party	\$938.60
	Family	\$1,197.36
Supplemental - HMSA Supplemental Medical, Drug, Vision	Self	\$298.70
	Two-Party	\$724.87
	Family	\$924.59
<b>DENTAL PLAN</b>		
HDS Dental	Self	\$29.42
	Two-Party	\$58.83
	Family	\$96.78
HDS Supplemental Dental	Self	\$15.63
	Two-Party	\$31.25
	Family	\$46.88
<b>VISION PLAN</b>		
VSP Vision	Self	\$6.08
	Two-Party	\$11.26
	Family	\$14.71
<b>CHIROPRACTIC</b>		
RSN Chiropractic	Self	\$1.37
	Two-Party	\$2.75
	Family	\$2.91

\*\*The prescription drug rates are subject to increase depending on the outcome of the protest/appeal.

**HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND  
 COBRA ACTIVE EMPLOYEES  
 ALL BU'S EXCEPT BU12  
 HSTA VEBA ACTIVE EMPLOYEES WHO OPT TO TRANSFER TO EUTF PLANS (BU 05,45)  
 BU 05, 45 EMPLOYEES HIRED ON OR AFTER JANUARY 1, 2011**

**EFFECTIVE MARCH 1, 2012**

<b>Benefit Plan</b>	<b>Type of Enrollment</b>	<b>Total COBRA Premium</b>
<b>MEDICAL PLANS</b>		
PPO - 90/10 Plan - HMSA Medical	Self	\$348.37
	Two-Party	\$845.64
	Family	\$1,078.43
PPO - 80/20 Plan - HMSA Medical	Self	\$332.42
	Two-Party	\$806.90
	Family	\$1,029.04
**Prescription Drug	Self	\$62.02
	Two-Party	\$150.72
	Family	\$192.05
HMO - HMSA Medical	Self	\$388.64
	Two-Party	\$943.44
	Family	\$1,203.15
**EUTF HMO Prescription Drug	Self	\$68.99
	Two-Party	\$167.69
	Family	\$213.63
HMO - Kaiser Comprehensive Medical Kaiser Prescription Drug	Self	\$439.33
	Two-Party	\$1,067.53
	Family	\$1,361.90
HMO - Kaiser Basic Medical Kaiser Prescription Drug	Self	\$382.87
	Two-Party	\$930.28
	Family	\$1,186.79
Supplemental - HMSA Medical HMSA Supplemental Prescription Drug	Self	\$209.04
	Two-Party	\$507.61
	Family	\$647.21
Supplemental - Royal State National Supplemental Prescription Drug	Self	\$40.12
	Two-Party	\$100.30
	Family	\$111.63
High Deductible Health Plan - HMSA HMSA Prescription Drug	Self	\$346.43
	Two-Party	\$840.93
	Family	\$1,072.45
<b>DENTAL PLAN</b>		
HDS Dental	Self	\$29.42
	Two-Party	\$58.83
	Family	\$96.78
<b>VISION PLAN</b>		
VSP Vision	Self	\$6.08
	Two-Party	\$11.26
	Family	\$14.71
<b>CHIROPRACTIC</b>		
Royal State National Chiropractic	Self	\$1.37
	Two-Party	\$2.75
	Family	\$2.91

**\*\*The prescription drug rates are subject to increase depending on the outcome of the protest/appeal.**

**HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND  
 COBRA ACTIVE EMPLOYEES  
 BU12  
 EFFECTIVE MARCH 1, 2012**

Benefit Plan	Type of Enrollment	Total COBRA Premium
<b>MEDICAL PLANS</b>		
PPO - 90/10 Plan - HMSA Medical	Self	\$289.80
	Two-Party	\$724.53
	Family	\$939.26
PPO - 80/20 Plan - HMSA Medical	Self	\$276.52
	Two-Party	\$691.34
	Family	\$896.23
**Prescription Drug	Self	\$45.82
	Two-Party	\$114.69
	Family	\$148.59
HMO - HMSA Medical	Self	\$330.50
	Two-Party	\$826.63
	Family	\$1,071.69
**EUTF HMO Prescription Drug	Self	\$53.28
	Two-Party	\$133.42
	Family	\$172.83
HMO - Kaiser Comprehensive Medical Kaiser Prescription Drug	Self	\$376.46
	Two-Party	\$941.01
	Family	\$1,219.51
HMO - Kaiser Basic Medical Kaiser Prescription Drug	Self	\$317.95
	Two-Party	\$794.70
	Family	\$1,029.91
Supplemental - HMSA Medical HMSA Supplemental Prescription Drug	Self	\$164.63
	Two-Party	\$414.14
	Family	\$544.07
Supplemental - Royal State National Supplemental Prescription Drug	Self	\$40.12
	Two-Party	\$100.30
	Family	\$111.63
High Deductible Health Plan - HMSA HMSA Prescription Drug	Self	\$288.13
	Two-Party	\$720.36
	Family	\$933.87
<b>DENTAL PLAN</b>		
HDS Dental	Self	\$29.42
	Two-Party	\$58.83
	Family	\$96.78
<b>VISION PLAN</b>		
VSP Vision	Self	\$6.08
	Two-Party	\$11.26
	Family	\$14.71
<b>CHIROPRACTIC</b>		
Royal State National Chiropractic	Self	\$1.37
	Two-Party	\$2.75
	Family	\$2.91

\*\*The prescription drug rates are subject to increase depending on the outcome of th protest/appeal.

<b>SECTION 1: COBRA PARTICIPANT DATA</b>	Please complete all applicable fields below. Social Security numbers are required to process enrollments.
--	--

Open Enrollment

COBRA Enrollee (Last Name, First Name, Middle Initial)

Social Security Number

Home Phone (\_\_\_\_\_) \_\_\_\_\_  
 Mobile Phone (\_\_\_\_\_) \_\_\_\_\_  
 Other Phone (\_\_\_\_\_) \_\_\_\_\_  
 Email \_\_\_\_\_

Gender  Male  Female  
 Birth Date: (MM/DD/YYYY)  
 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

COBRA Enrollee Residence Address

Check this box if your address has changed

Street \_\_\_\_\_  
 Line 2 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

COBRA Enrollee Mailing Address (if different from Mailing Residence Address)

Check this box if your address has changed

Street \_\_\_\_\_  
 Line 2 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

<b>SECTION 2: COBRA PLAN SELECTION:</b>	Make your selection by checking all the boxes of the appropriate benefit plans below. Select Self, Two-Party, Family, or Cancel/Waive coverage. Choose only one box in each plan selection. If you do not make a selection, you will be considered as "waiving" coverage.
<input type="checkbox"/> I (We) elect to continue coverage as indicated below and will be responsible for payment of the full cost of the selected coverage.	

Medical Plan Type	Carrier Selection	Choose only one box in each plan selection			
		Cancel/Waive	Self	2-Party	Family
PPO	PPO-90/10 <b>HMSA</b> Medical, Chiro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	PPO-80/20 <b>HMSA</b> Medical, Chiro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Drug	Prescription Drug (Not a valid selection w/ HMO, HDHP, or Supplemental plans)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO	HMO- <b>HMSA</b> Medical, Prescription Drug Coverage, Chiro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	HMO- <b>Kaiser</b> Basic, (Includes Prescription Drug Coverage), Chiro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	HMO- <b>Kaiser</b> Comprehensive, (Includes Prescription Drug Coverage), Chiro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HDHP	HDHP-High Deductible Health Plan <b>HMSA</b> (Includes Prescription Drug Coverage)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supplemental	Supplemental- <b>HMSA</b> (Includes Supplemental Prescription Drug Coverage), Chiro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Supplemental-Royal State National Insurance Company (Includes Supplemental Prescription Drug Coverage), Chiro ***	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Plans		Cancel/Waive	Self	2-Party	Family
Dental	Hawaii Dental Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision	Vision Service Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Chiro is billed separately.
- Prescription Drug for some selections is billed separately.

**SECTION 3: DEPENDENT INFORMATION AND ELECTION OF COBRA PLAN(S)**

List all eligible dependents you wish to cover and check the plan selections desired. Relationship\* Key: SP=Spouse, DP=Domestic Partner, CH=your Child or your Spouse's Child, DPCH= Domestic Partner's Child, GC=Guardianship/Foster child, SC = Step Child, DC=Disabled Child if your child is age 19 or over and is also disabled.

Add	Delete	Dependent:		Birth Date (MMDDYYYY)	Social Security Number**	Relationship *	Gender M / F	Medical	Drug	Dental	Vision
		Last Name (if different),	First Name, Middle Initial								
<input type="checkbox"/>	<input type="checkbox"/>			/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>			/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>			/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>			/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Detailed eligibility information is available at [www.eutf.hawaii.gov](http://www.eutf.hawaii.gov) in the EUTF Administrative Rules, Chapter 87A, Hawaii Revised Statutes. Dependent Certification and Student Certification.

I certify that all of my dependent children meet eligibility requirements for enrollment in the COBRA plans. \_\_\_\_\_ (initials)

**SECTION 4: COBRA PAYMENT INFORMATION**

Checks are to be made payable to each respective insurance carrier. Payment is due the first day of each month. Failure to make payment by the due date will result in the termination of this coverage and will not be reinstated. The monthly COBRA rates are subject to change in accordance with federal law.

Hawaii Medical Service Association (HMSA): Oahu (808) 948-6499, Toll-free 1 (800) 766-4672 P.O. Box 860, Attn: Membership Services Dept., Honolulu, HI 96808-0860	ChiroPlan Hawaii: Honolulu (808) 621-4744, Neighbor Islands 1 (800) 414-8445 711 Kilani Avenue, Suite 3, Wahiawa, HI 96786
Kaiser Permanente (Kaiser): (808) 432-5955, Toll-free 1 (800) 966-5955 711 Kapiolani Boulevard, Honolulu, HI 96813	Hawaii Dental Service (HDS): (808) 529-9310, Toll-free 1 (866) 702-3883 700 Bishop Street Suite 700, Honolulu, HI 96813
InformedRx [billing handled by ARM Ltd.]:  Toll-free: 1 (800) 533-6977 ARM Ltd., 171 West Wing Street #210, Arlington Heights, IL 60005	Vision Service Plan (VSP): Honolulu (808) 532-1600, Toll-free 1 (800) 522-5162 P.O. Box 997100, Sacramento, CA 95899
Royal State National Insurance Company (RSN):  (808) 539-1600, Toll-free: 1 (800) 890-9022 819 S Beretania St, Honolulu, HI 96813	

**SECTION 5: COBRA PARTICIPANT SIGNATURE**

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand if I do not make a selection or check the "waive" box, it will be considered a "waive." I understand that the benefit elections made on this application are in effect for as long as I continue to meet COBRA's eligibility requirements, or until I elect to change them subject to the provisions of COBRA. I have read the benefit materials, understand the limitations and qualifications of the COBRA benefits program and agree to abide by the terms and conditions of the benefit plans selected.

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. This form supersedes all forms and submissions I previously made for COBRA 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 penalty for perjury.

COBRA Participant Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

If you do not submit this completed Election Form by the due date, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you finish this completed Election Form before the due date.

<b>SECTION 1: COBRA PARTICIPANT DATA</b>	Please complete all applicable fields below. Social Security numbers are required to process enrollments.
--	--

 Open Enrollment

COBRA Enrollee (Last Name, First Name, Middle Initial) \_\_\_\_\_

Social Security Number \_\_\_\_\_

 Home Phone (\_\_\_\_\_) \_\_\_\_\_  
 Mobile Phone (\_\_\_\_\_) \_\_\_\_\_  
 Other Phone (\_\_\_\_\_) \_\_\_\_\_  
 Email \_\_\_\_\_

 Gender  Male  Female  
 Birth Date: (MM/DD/YYYY) \_\_\_\_\_

COBRA Enrollee Residence Address

 Check this box if your address has changed

 Street \_\_\_\_\_  
 Line 2 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

COBRA Enrollee Mailing Address (if different from Mailing Residence Address)

 Check this box if your address has changed

 Street \_\_\_\_\_  
 Line 2 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

<b>SECTION 2: COBRA PLAN SELECTION:</b>	Make your selection by checking all the boxes of the appropriate benefit plans below. Select Self, Two-Party, Family, or Cancel/Waive coverage. Choose only one box in each plan selection. If you do not make a selection, you will be considered as "waiving" coverage.
<input type="checkbox"/> I (We) elect to continue coverage as indicated below and will be responsible for payment of the full cost of the selected coverage.	

Medical Plan Type	Carrier Selection	Choose only one box in each plan selection		
		Cancel/Waive	Self	Family
PPO	PPO-90/10 <b>HMSA</b> Medical, Prescription Drug, Vision, Chiro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	PPO-80/20 <b>HMSA</b> Medical, Prescription Drug, Vision, Chiro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO	HMO- <b>Kaiser</b> Medical, (Includes Prescription Drug Coverage), Vision, Chiro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supplemental	Supplemental- <b>HMSA</b> Medical, Drug and Vision, Chiro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Plans		Cancel/Waive	Self	Family
Dental	Hawaii Dental Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Supplemental Hawaii Dental Service ***	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision	Vision Service Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Note: The enrollment of HSTA VEBA members into the health and other benefit 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.

- Chiro is billed separately.
- Prescription Drug for some selections is billed separately.
- Vision for some selections is billed separately.

**SECTION 3: DEPENDENT INFORMATION AND ELECTION OF COBRA PLAN(S)**

List all eligible dependents you wish to cover and check the plan selections desired. Relationship\* Key: SP=Spouse, DP=Domestic Partner, CH=your Child or your Spouse's Child, DPCH= Domestic Partner's Child, GC=Guardianship/Foster child, SC = Step Child, DC=Disabled Child if your child is age 19 or over and is also disabled.

Add	Delete	Dependent:		Birth Date (MMDDYYYY)	Social Security Number**	Relationship *	Gender		Medical	Drug	Dental	Vision
		Last Name (if different), First Name, Middle Initial					M / F					
<input type="checkbox"/>	<input type="checkbox"/>			/ /					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>			/ /					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>			/ /					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>			/ /					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Detailed eligibility information is available at [www.eutf.hawaii.gov](http://www.eutf.hawaii.gov) in the EUTF Administrative Rules, Chapter 87A, Hawaii Revised Statutes. Dependent Certification and Student Certification.

I certify that all of my dependent children meet eligibility requirements for enrollment in the COBRA plans. \_\_\_\_\_ (initials)

**SECTION 4: COBRA PAYMENT INFORMATION**

Checks are to be made payable to each respective insurance carrier. Payment is due the first day of each month. Failure to make payment by the due date will result in the termination of this coverage and will not be reinstated. The monthly COBRA rates are subject to change in accordance with federal law.

Hawaii Medical Service Association (HMSA): Oahu (808) 948-6499, Toll-free 1 (800) 766-4672 P.O. Box 860, Attn: Membership Services Dept., Honolulu, HI 96808-0860	ChiroPlan Hawaii: Honolulu (808) 621-4744, Neighbor Islands 1 (800) 414-8445 711 Kilani Avenue, Suite 3, Wahiawa, HI 96786
Kaiser Permanente (Kaiser): (808) 432-5955, Toll-free 1 (800) 966-5955 711 Kapiolani Boulevard, Honolulu, HI 96813	Hawaii Dental Service (HDS): (808) 529-9310, Toll-free 1 (866) 702-3883 700 Bishop Street Suite 700, Honolulu, HI 96813
Royal State National Insurance Company (RSN):  (808) 539-1600, Toll-free: 1 (800) 890-9022 819 S Beretania St, Honolulu, HI 96813	Vision Service Plan (VSP): Honolulu (808) 532-1600, Toll-free 1 (800) 522-5162 P.O. Box 997100, Sacramento, CA 95899

**SECTION 5: COBRA PARTICIPANT SIGNATURE**

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand if I do not make a selection or check the "waive" box, it will be considered a "waive." I understand that the benefit elections made on this application are in effect for as long as I continue to meet COBRA's eligibility requirements, or until I elect to change them subject to the provisions of COBRA. I have read the benefit materials, understand the limitations and qualifications of the COBRA benefits program and agree to abide by the terms and conditions of the benefit plans selected.

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. This form supersedes all forms and submissions I previously made for COBRA 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 penalty for perjury.

COBRA Participant Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

If you do not submit this completed Election Form by the due date, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you finish this completed Election Form before the due date.