HSTA COBRA JAN 2011	Hawaii Employer-Union Health Benefits Trust Fund **HSTA: COBRA ELECTION FORM**	PLEASE SUBMIT THIS HSTA COBRA ELECTION FORM TO THE EUTF

SECTION 1: COBRA PARTICIPANT DATA

Please complete all applicable fields below.
Social Security numbers are required to process enrollments.

☐ Open Enrollment

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

____

Work Phone (______) ______________________
Home Phone (______) ______________________
Mobile Phone (______) ______________________

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 above)
Street______________________
Line 2______________________
City______________ State______ Zip Code__________

COBRA Enrollee's Social Security Number (SSN)

____

COBRA Enrollee:
Gender ☐ Male ☐ Female
Birth Date: (MM/DD/YYYY)

______/______/______

Participant Name (if different) (Last Name, First Name, Middle Initial)

____

Work Phone (______) ______________________
Home Phone (______) ______________________
Mobile Phone (______) ______________________

Participant Residence Address
(☐ Check this box if your address has changed)
Street______________________
Line 2______________________
City______________ State______ Zip Code__________

Participant Mailing Address (if different from above)
Street______________________
Line 2______________________
City______________ State______ Zip Code__________

Participant's Social Security Number (SSN)

____

Participant:
Gender ☐ Male ☐ Female
Birth Date: (MM/DD/YYYY)

______/______/______

SECTION 2: COBRA PLAN SELECTION:

☐ I (We) elect to continue coverage as indicated below and will be responsible for the full cost of the coverage.

Medical Plan ☐ **Cancel/Waive Medical Coverage**

Choose only one box in each plan section

Type	Carrier Selection	Self	2-Party	Family
PPO	Fully Insured **HMSA** PPO **80/20** Medical and Drug (HMSA), VSP, Chiroplan Hawaii	☐	☐	☐
	Fully Insured **HMSA** PPO **90/10** Medical and Drug (HMSA), VSP, Chiroplan Hawaii	☐	☐	☐
HMO	Kaiser Medical and Drug, VSP, Chiroplan Hawaii	☐	☐	☐
Supplemental	Supplemental-HMSA Medical, Drug and Vision, Chiroplan Hawaii	☐	☐	☐
	Supplemental-HDS Dental	☐	☐	☐

Other Plans	Cancel/Waive	Self	2-Party	Family
Vision Service Plan (VSP)	☐	☐	☐	☐
Primary HDS Dental	☐	☐	☐	☐

The EUTF created new health benefit plans for HSTA VEBA COBRA members in response to the December 7, 2010 oral ruling by Judge Sakamoto. The new plans offer HSTA VEBA COBRA members the same standard of coverage in benefits that they enjoyed under their HSTA VEBA COBRA plans. All HSTA VEBA COBRA members will be transitioned to the newly created EUTF plans that offer the same standard of coverage in benefits on January 1, 2011.

PARTICIPANT'S SSN ______________________________

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

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

Add	Delete	Dependent: Last Name (if different), First Name, Middle Initial	Birth Date (MMDDYYYY)	Social Security Number	*Relationship	Gender M/F
☐	☐		/ /			
☐	☐		/ /			
☐	☐		/ /			
☐	☐		/ /			
☐	☐		/ /			

Detailed eligibility information is available at www.eutf.hawaii.gov in the EUTF Administrative Rules, Chapter 87A, Hawaii Revised Statutes.

Dependent Certification and Student Certification– See Section 4.6 and 4.7 of "Instructions for Completing Form EC-1" for more information.

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: 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
	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

NOTE: The enrollment of HSTA VEBA COBRA members into these new health and other benefit plans is being done solely to comply with Judge Sakamoto's oral ruling and not to create any constitutional or contractual right to the benefits provided by these plans. Please note that the State does not agree with Judge Sakamoto's ruling and reserves the right to move HSTA VEBA COBRA members into regular EUTF COBRA plans if Judge Sakamoto's ruling is overturned or modified.

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.