Please print or type clearly. If the EC-1H form is unreadable, incomplete, or does not contain all information required, it may be sent back to you without action.

Submit the EC-1H form to the Department of Education – Health Benefits and Awards Unit (DOE – HBAU) or Hawaii Public Charter Schools (HIPCS) for verification, signature, and routing.

SECTION 1 - EMPLOYEE DATA

1. Enter your full legal name as recorded on your Social Security card.
2. Enter your contact information.
3. Enter your address information. If your mailing address differs from your residential address, you need to enter both addresses to ensure that correspondence reaches you.
4. Mark the New Hire box if:
   A) You are a new employee; and enter the effective date you were hired, or
   B) Your employment status is changing from part time (25% FTE) to full time (50% -100% FTE) employment; and enter the effective date you will become full time.
5. Mark the Open Enrollment box **only** during the annual or special Open Enrollment period.
6. Mark the Termination box if you are terminating your employment; and enter your close of business date.
7. If you are enrolling with the EUTF for the first time, you are required to provide your Social Security Number.
8. Enter your gender and birth date. If enrolling for the first time, EUTF is unable to process your paperwork without a birth date.
9. Mark the Mid-Year Qualifying Event box if you have made any changes during the year; and enter the date of the event. The following are the most common events: Address Change, Birth, Divorce, Loss of Coverage, Acquisition of Coverage, Marriage, Retirement, Death, Transfer In, Transfer Out, etc. If there are simultaneous events, please describe the most prevalent event; for example, if the event is a birth and an address change, enter Birth in the event section.
10. If you are Married, or in a Civil Union, or in a Domestic Partnership please be sure to check the appropriate boxes and include the date you were Married, or entered in a Civil Union, or entered in a Domestic Partnership. You must attach a copy of your civil union certificate received from the Department of Heatlh.
11. Special Note: If your Spouse or Civil Union Partner or Domestic Partner is a State or County Employee or Retiree and is not being enrolled in your plans, please provide his/her Social Security Number. Dual enrollment in EUTF plans is not allowed under EUTF Administrative Rule 4.03. If both you and your Spouse/Civil Union Partner/Domestic Partner are employee beneficiaries, only one of you may enroll in an EUTF Family plan, or if no other dependents are involved, both may enroll in EUTF Self plans. If your Spouse/Civil Union Partner/Domestic Partner has coverage outside of the EUTF that provides family coverage, this rule does not preclude you from also enrolling in an EUTF family coverage plan to cover your Spouse/Civil Union Partner/Domestic Partner. The dual enrollment rule does not apply if your other coverage is not provided by the EUTF.

SECTION 2 – COVERAGE AND DEDUCTION START SELECTION

1. If the “Qualifying Event” that applies to you is listed in Section 2 [Adoption, Birth, Guardianship, New Eligible Student, Marriage, Civil Union, Domestic Partner, New Hire, Newly Eligible, Placement for Adoption, Reinstatement in Employment, Return from Authorized Leave of Absence (if not currently enrolled)], you have three choices of when your coverage and premium contributions begin. Select one of the three.
2. If no selection is made, the first option (coverage starts day of the event and premium contribution starts first day of the pay period in which the effective date of coverage occurs) will be the default option selected.
3. For the following events: Marriage, Civil Union, Domestic Partner and New Eligible Student; the event date is when DOE – HBAU / HIPCS receives proper notification. Your effective date will be based on your event date and the box you selected.
4. DOE – HBAU / HIPCS to complete Effective Date of Coverage and Premium Contribution begins date.

SECTION 3 – PLAN SELECTION

Mark all plans you are enrolled in/want to enroll in. If you do not make a selection, you will be considered as cancelling/waiving coverage.

1. Carefully review each selection that you make. You can choose ONE medical, ONE dental, and ONE vision plan. Your prescription drug plan will depend on the medical plan that you select.
2. If you do not want any plan coverage, mark the "Cancel/Waive" box. If you do not make a selection or check the “Cancel/Waive” box, you will be considered as waiving the selection(s). To be eligible for Supplemental medical plan coverage, you must have other medical coverage from another source, not including this employer.
3. The RSN ChiroPlan is included with all medical plans.
4. If you have other health plan coverage and do not want to participate in EUTF’s HSTA VB type plans, mark the “Cancel/Waive” box for each plan that you choose not to select.
5. Life insurance is provided by this employer for the employee only.
6. FOR STATE EMPLOYEES ONLY: Premium Conversion Plan (PCP) - PCP is a voluntary benefit plan, administered by the Department of Human Resources Development (DHRD) that allows employees to purchase their health benefit plans on a pretax basis and is being offered pursuant to Section 125 of the Internal Revenue Code. For more information, go to the DHRD website at http://hawaii.gov/hrd/. Please inquire with DOE – HBAU / HIPCS or DHRD on completing a PCP-2 form.
   -Mark one of the following boxes: ☐ Enroll, ☐ Change Amount, ☐ Cancel PCP, or ☐ Do NOT Enroll.

Write your name in the top right corner.

SECTION 4 - DEPENDENT INFORMATION AND PLAN SELECTIONS

1. Enter your Dependent(s) data. If enrolling your dependent for the first time, enter his/her birth date and social security number. Social Security Number is not a required field when submitting an initial EC-1H for new birth. Please be sure to submit an EC-1H to update our records for your newborn once the information is received/issued by the Social Security Administration. Otherwise, you may leave the birth date blank and list your dependent's EUTF ID number. If making changes to your dependent's data, enter the corrected item. If listing more than 6 dependents, write/type "Continued" on the last line of the Dependent section. Attach a separate sheet of white letter sized paper to your EC-1H.
2. Use the following Relationship codes:

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

3. For Relationship codes with √ or √√ or √√√ or √√√√, please see item #8 and #9 below for other required forms.
4. Gender – Write/type either M or F.
5. Plan Selections. YOUR DEPENDENTS CAN BE ENROLLED ONLY IN THE SAME PLANS IN WHICH YOU ARE CURRENTLY ENROLLED. If you do not want any plan coverage for any of your dependents, mark the "Self" box in Section 3.
6. Dependent certification. Your initials confirm that you are certifying that all of your dependent children are eligible to be enrolled under your enrollment. You also confirm that you will provide a copy of your child(ren)'s birth certificate and/or social security card if requested by the EUTF. You also confirm that you will provide a copy of your child(ren)'s student verification letter, signed by the registrar, as required by the EUTF.
7. Civil Union Partner Certification. Your initials confirm that you are certifying you have completed all the required forms in accordance with Civil Union.
8. Domestic Partner Certification. Your initials confirm that you are certifying you have completed all the required forms in accordance with Domestic Partnership.
9. If you are enrolling a Civil Union Partner (and Civil Union Partner's children) or Domestic Partner (and Domestic Partner's children), you are required to complete all required forms in accordance with the instructions for Civil Union Partner or Domestic Partner. You are responsible to obtain, complete and submit all necessary documentation to the EUTF through DOE - HBAU / HIPCS within 30 days from your event date. Failure to do so will result in no action taken on your Civil Union Partner or Domestic Partner coverage. You may add your Civil Union Partner or Domestic Partner at anytime outside of Open Enrollment, provided all required documents have been received by the DOE - HBAU / HIPCS within 30 days of the event date. Visit the EUTF website at eutf.hawaii.gov for detailed instructions regarding Civil Union Partnership or Domestic Partnership.10. Other EUTF and/or DRHD forms to include with EC-1H (if applicable):
   - √ Civil Union Certificate issued by the State of Hawaii Department of Health (printed copies of the temporary on-line certificate are acceptable)
   - √ EUTF Declaration of Domestic Partnership
   - √ Affidavit of "Dependency" for Tax Purposes
   - √ DHRD Civil Union Acknowledgement Form (State Employees with PCP enrolling Domestic/Civil Partner)
   - √ DHRD PCP 2 form (For State Employees Only)
   - √√ Legal documents for guardianship or foster child
   - √√√ EUTF Declaration of Domestic Partnership or EUTF Declaration of Termination of Domestic Partnership
   - √√√ Affidavit of "Dependency" for Tax Purposes
   - √√√ DHRD Domestic Partnership Acknowledgement Form (State Employees with PCP enrolling Domestic/Civil Partner)
   - √√√ DHRD PCP 2 form (For State Employees Only)
   - √√√√ Disability Certification For Dependent Children (Form D-1) for enrolling a disabled child

SECTION 5 – OTHER INSURANCE INFORMATION

1. If you or any of your dependents have health benefit coverage through another employer's health plan(s) (private / Federal), please complete this section. If you selected a supplemental medical plan, you are required to complete this section.
2. The information that you provide does not determine how your benefits are coordinated. COB rules are determined by the health benefit plans and follow the guidelines of the National Association of Insurance Commissioners (www.naic.org).

Note: To be eligible for coverage under any Supplemental Health Benefit Plan, you and your eligible dependent(s) must be covered under another employer group plan (private / Federal).

SECTION 6 - EMPLOYEE AUTHORIZATION AND SIGNATURE

Your signature certifies that the information provided in this application is true and complete. You also agree to abide by the terms and conditions of the benefit plans selected. You are authorizing your employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from employee's salary, wages, pension or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

You must submit the EC-1H through the DOE – HBAU / HIPCS. The DOE – HBAU / HIPCS confirms that you are a current employee and are eligible for health benefits through the EUTF.

EMPLOYER VALIDATION **[for EMPLOYER USE ONLY]**

1. Department ID # - please enter your appropriate Department ID code; for example, 010021 for Department of Education.
2. Department and Division/School - Please enter the appropriate information.
3. Bargaining Unit number - Please enter the appropriate bargaining unit for this employee.
4. Enter the date the EC-1H was received from the employee. The date recorded should be the date that the **DOE - HBAU / HIPCS** received it.
5. Please provide contact phone and fax numbers.
6. DOE - HBAU / HIPCS designee signature certifies that the employee-beneficiary is eligible for coverage through the EUTF as defined in Chapter 87A, Hawaii Revised Statutes.
7. Enter date the EC-1H was signed by the DOE - HBAU / HIPCS designee.

EC-1H
Rev. Dec 2011

Hawaii Employer-Union Health Benefits Trust Fund

EC-1H: Enrollment Form for HSTA VB Active BU 05/45 Employees

Clear Form

PLEASE SUBMIT THIS FORM EC-1H TO THE DOE - HBAU / HIPCS FOR ROUTING

SECTION 1: EMPLOYEE DATA

Please complete all applicable fields below. Social Security numbers are required to process new hires and dependent enrollments. **

Name (Last, First, Middle)

_____

Home Phone (_____) _____
Mobile Phone (_____) _____
Work Phone (_____) _____

Email _____

Residence Address (☐ Check this box if your address has changed)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

Mailing Address (if different from above)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

☐ New Hire
Date of Hire (MM/DD/YYYY)

____/____/_____

☐ Open Enrollment

☐ Termination
Date of Termination (MM/DD/YYYY)

____/____/_____

Employee's Social Security Number (SSN) or EUTF ID Number

_____

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

____/____/_____

☐ Mid-Year Qualifying Event (describe)

_____

Event Date: ____ / ____ / ____

Marital Status ☐ Married ☐ Single
Marriage Date: (MM/DD/YYYY)
(☐ Check this box if status change)

____ / ____ / ____

Civil Union Partner (Civil Union Status)
☐ IRS Qualified ☐ Not Qualified
Civil Union Date: (MM/DD/YYYY)
(☐ Check this box if status change)

____ / ____ / ____

Domestic Partner (DP Status)
☐ IRS Qualified ☐ Not Qualified
DP Date: (MM/DD/YYYY)
(☐ Check this box if status change)

____ / ____ / ____

Special Note: If your Spouse or Civil Union Partner or Domestic Partner is a State or County Employee or Retiree and is not being enrolled in your plans, please provide his/her SSN:

_____

Section 2: COVERAGE AND DEDUCTION START SELECTION

If events are filed within 30 days of qualifying event date, some events allow for a selection of the Coverage and Premium Contribution Start Dates.
If your event is listed below, please select one of the three options, otherwise skip this section.

Qualifying Events for this Section
Adoption, Birth, Guardianship, New Eligible Student, Marriage, Civil Union, Domestic Partner, New Hire, Newly Eligible, Placement for Adoption, Reinstatement in Employment, Return from Authorized Leave of Absence (if not currently enrolled)

Available Options for this Section
☐ 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 selection is made, this option will be used)
☐ Coverage and premium contributions start 1st day of the **first** pay period following event
☐ Coverage and premium contributions start 1st day of the **second** pay period following event

Completed by DOE - HBAU / HIPCS → Effective Date of Coverage: _____ Premium Contribution begins: _____

SECTION 3: PLAN SELECTION

Make your selection by checking the 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.

Medical Plan Type	Carrier Selection	Choose only one box in each plan selection: Cancel/Waive	Self	2-Party	Family
PPO	PPO-90/10 **HMSA** Medical, Prescription Drug, Vision, Chiro	☐	☐	☐	☐
	PPO-80/20 **HMSA** Medical, Prescription Drug, Vision, Chiro	☐	☐	☐	☐
HMO	HMO-**Kaiser** Medical, (Includes Prescription Drug Coverage), Vision, Chiro	☐	☐	☐	☐
Supplemental	Supplemental-**HMSA** Medical, Drug and Vision, Chiro ***	☐	☐	☐	☐

*** To be eligible for coverage under any Supplemental Health Benefit Plan, you and your eligible dependent(s) must be covered under another employer group health plan (private/Federal)

Other Plans		Cancel/Waive	Self	2-Party	Family
Dental	Hawaii Dental Service	☐	☐	☐	☐
	Supplemental Hawaii Dental Service ***	☐	☐	☐	☐
Vision	Vision Service Plan	☐	☐	☐	☐
Life	Royal State National	☐	☐		

For STATE Employees ONLY: Premium Conversion Plan ☐ Enroll ☐ Change Amount ☐ Cancel PCP ☐ Do NOT Enroll

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.

SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS

Please list all dependents enrolled or who you want to add/delete from your plan.

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, CU=Civil Union Partner, DP=Domestic Partner, CH=your Child or your Spouse's Child, CUCH=Civil Union Partner'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. Social Security Number **: Social Security Number is not a required field when submitting an initial EC-1H for new birth. Please be sure to submit an EC-1H to update our records for your newborn once the information is received/issued by SSA.

Add	Delete	Dependent: Last Name (if different), First Name, Middle Initial	Birth Date (MM/DD/YYYY)	Social Security Number**	Relationship *	Gender M / F	Medical	Drug	Dental	Vision
☐	☐		/ /				☐	☐	☐	☐
☐	☐		/ /				☐	☐	☐	☐
☐	☐		/ /				☐	☐	☐	☐
☐	☐		/ /				☐	☐	☐	☐
☐	☐		/ /				☐	☐	☐	☐

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

Dependent Certification – See Section regarding Dependent Certification on "Instructions for Completing Form EC-1H" for more information.

I certify that my dependent children meet eligibility requirements for enrollment in the EUTF plans. _____ **(initials)**

Civil Union Partner Certification – See Section regarding Civil Union Partner Certification on "Instructions for Completing Form EC-1H" for specific instructions.

I have attached all documentation as required in the Civil Union Partner Enrollment Instructions. _____ **(initials)**

Domestic Partner Certification – See Section regarding Domestic Partner Certification on "Instructions for Completing Form EC-1H" for specific instructions.

I have attached all documentation as required in the Domestic Partner Enrollment Instructions. _____ **(initials)**

SECTION 5: OTHER INSURANCE INFORMATION

*** To be eligible for coverage under any Supplemental Health Benefit Plan, you and your eligible dependent(s) must be covered under another employer group health plan (private/Federal)

If you or any of your dependents are covered through another employer's health plan(s), please provide the type of plan, name of the plan, subscriber's name, effective date of the plan, and the health plan coverage (self, two-party, family).

Type of Plan	Name of the Plan (Carrier's Name)	Subscriber's Name	Effective Date	Health Plan Coverage Self	2-Party	Family
			/ /	☐	☐	☐
			/ /	☐	☐	☐

SECTION 6: EMPLOYEE AUTHORIZATION AND 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 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 selected. I authorize my employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from employee's salary, wages, pension 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 of enrollment, denial of future enrollment, or civil damages. This form supersedes all forms and submissions I 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 penalty for perjury.

Employee Signature: _____ Date Signed: _____

Department ID#	Department	Division/School	Bargaining Unit
Date EC-1H Received in DOE - HBAU / HIPCS Office / /		DOE - HBAU / HIPCS Phone Number	DOE - HBAU / HIPCS Fax Number
DOE - HBAU / HIPCS Printed Name DOE - HBAU / HIPCS Signature:			Date of DOE - HBAU / HIPCS Signature / /
Remarks:			