Print or type clearly. If this form is unreadable, incomplete, or does not contain all information required, it will be sent back to you without action.

SECTION 1 - RETIREE 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 Open Enrollment box **only** during the annual or special Open Enrollment period.
5. If you are enrolling with the EUTF for the first time as a retiree, you are required to provide your Social Security Number.
6. Enter your gender and birth date. If enrolling for the first time, EUTF is unable to process your paperwork without a birth date.
7. 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, 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.
8. If you are Married, or in a Civil Union, or in a Domestic Partnership please be sure to check appropriate boxes and include date you were Married, or entered into a Civil Union, or entered into a Domestic Partnership. You must attach a copy of your civil union certificate received from the Department of Health.
9. 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/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 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 CONTRIBUTION START SELECTION

Complete this section only if you pay towards health plan benefits

1. If the "Qualifying Event" that applies to you is listed in Section 2 [Adoption, Birth, Marriage, Civil Union, Domestic Partner, Placement for Adoption, Guardianship, New Eligible Student], 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 EUTF receives proper notification. Your effective date will be based on your event date and the box you selected.

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 choice of the prescription drug plan will depend on the medical plan that you select. If you select an HMO, your medical selection will include a prescription drug plan. If you select a PPO plan, you must select the prescription drug plan if you want drug coverage. If you don't make a selection, you will not have any prescription drug coverage.
2. You may choose to elect only the medical PPO plan without the prescription drug plan or vice versa. If you want both the medical and drug plans, please mark the appropriate boxes. 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).
3. If you have other health plan coverage and do not want to participate in the EUTF plans, mark the "Cancel/Waive" box for each plan that you choose not to select.
4. Life Insurance is provided by the state/county for the retiree only.

Write your name in the top right corner of page 2.

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-2 for new birth. Please be sure to submit an EC-2 to update our records for your newborn once the is information 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 3 dependents, write/type "Continued" on the last line of the Dependent section. Attach a separate sheet of white letter sized paper to your EC-2.
2. Use the following Relationship codes:

SP = Spouse	CH = Child	SC = Step Child
CU = Civil Union Partner √	CUCH = Civil Union 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.
7. Student certification. Your initials confirm that you are certifying that all of your dependent children ages 19 through 23, are eligible to be enrolled under your enrollment as full-time students. You further confirm that you will provide a copy of your child(ren)'s student verification letter, signed by the registrar, as required by the EUTF.
8. Civil Union Certification. Your initials confirm that you are certifying you have completed all the required forms in accordance with Civil Union.
9. Domestic Partner Certification. Your initials confirm that you are certifying you have completed all the required forms in accordance with Domestic Partnership.
10. 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 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 EUTF 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.
11. If you are adding an Adopted Child, Civil Union Partner and child, Domestic Partner and child or a Disabled Child, please contact the EUTF at 808-586-7390 or toll free, 1-800-295-0089 or visit our website at eutf.hawaii.gov for more information. Other EUTF forms to include with EC-2 (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
    - √√ 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
    - √√√√ Disability Certification For Dependent Children (Form D-1) for enrolling a disabled child

SECTION 5 – MEDICARE

IMPORTANT: If you or your dependent(s) are Medicare eligible and are enrolled in a Non-EUTF Medicare Part D prescription drug plan, please provide the name(s) of those enrolled in the Non-EUTF plan. Please ensure that you carefully read the implications of being enrolled in a Non-EUTF Medicare Part D prescription drug plan. Additional information is included in your Retiree Open Enrollment Guide. You can obtain detailed information regarding Medicare Part D at the Medicare website, www.medicare.gov.

IMPORTANT NOTICE: When you or your dependent(s) become eligible for Medicare Part B, you or your dependent(s) must enroll in Medicare Part B and forward a proof of enrollment (Medicare card showing Part B effective date and Direct Deposit Authorization Form) to the EUTF. Failure to comply may result in loss of all health benefits coverage. If you or your dependent(s) have recently enrolled with Medicare Part B, please complete this section and submit this EC-2 form with a copy of your Medicare card and a direct deposit agreement form to the EUTF

SECTION 6 – OTHER INSURANCE INFORMATION

1. If you or any of your dependents have health benefit coverage through another employer's health plan(s) (private / Federal), 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).

SECTION 7 – RETIREE SIGNATURE

Your signature certifies that the information provided in this application is true and complete. Retiree agrees to abide by the terms and conditions of the benefit plans selected. Retiree affirms that any listed dependent child, aged 19 through 23, is attending a college, university or technical school as a full-time student and is also unmarried. Please enter date of Retiree's signature.

You must submit the EC-2 to the EUTF office. You may send it by mail or hand deliver. The addresses are printed at the bottom of page 2 of the enrollment form.

EC-2
Rev. Dec 2011

Hawaii Employer-Union Health Benefits Trust Fund

EC-2: Enrollment Form for Retirees

Clear Form

PLEASE SUBMIT THIS FORM EC-2 TO THE EUTF

SECTION 1: RETIREE DATA

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

Name (Last, First, Middle)

_____

Home Phone (_____) _____

Mobile Phone (_____) _____

Other 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 _____

☐ Open Enrollment

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

_____

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

_____/_____/_____

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

_____/_____/_____

If you are including your Spouse or Civil Union Partner or Domestic Partner in your health benefit plans, please complete Section 4

☐ Mid-Year Qualifying Event (describe)

_____

Event Date: _____/_____/_____

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: _____ or

EUTF ID: _____

SECTION 2: COVERAGE AND DEDUCTION START SELECTION

Skip this section if RETIREE does NOT pay towards health plan benefits.

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, Marriage, Civil Union, Domestic Partner, Placement for Adoption, Guardianship, New Eligible Student

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

√ (1st or 16th of the month)

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 No Prescription Drug Coverage	☐	☐	☐	☐
	Prescription Drug (Not a valid selection w/ HMO)	☐	☐	☐	☐
HMO	HMO-**Kaiser** Medical (Includes Prescription Drug Coverage)	☐	☐	☐	☐
Other Plans		**Cancel/Waive**	**Self**	**2-Party**	**Family**
Dental	Hawaii Dental Service	☐	☐	☐	☐
Vision	Vision Service Plan	☐	☐	☐	☐
Life	Royal State National	☐	☐		

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-2 for new birth. Please be sure to submit an EC-2 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 and Student Certification– See Section regarding Dependent and Student Certification on "Instructions for Completing Form EC-2" for more information.

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

I certify that all of my dependent children ages 19 through 23, are full time students at an accredited scholastic institution. _____ **(initials)**

Civil Union Partner Certification – See Section regarding Civil Union Partner Certification on "Instructions for Completing Form EC-2" 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-2" for specific instructions.

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

SECTION 5: MEDICARE

HRS Chapter 87A-23(4) requires eligible beneficiaries to enroll in Medicare Part B as a condition of receiving contributions and participating in the EUTF retiree benefit plans. If you or your dependent(s) recently enrolled in Medicare Part B, or have not already done so, please submit a copy of the Medicare card and EUTF Direct Deposit Agreement Form to the EUTF without delay and complete this section to initiate quarterly reimbursement.

Name of Enrollee:

Medicare Claim #: (ID Number listed on the red, white and blue Medicare card)

Non-EUTF Medicare Part D

If you or your dependent(s) are enrolled in a non-EUTF Medicare Part D prescription drug plan, please read Section 5 on the instruction form and enter the name(s) of those enrolled in a non-EUTF Medicare Part D plan.

Name(s):

SECTION 6: OTHER INSURANCE INFORMATION

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 7: RETIREE 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

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.

Retiree Signature: _____ Date Signed: _____

Please submit your signed EC-2 form by mail to:

EUTF
P.O. Box 2121
Honolulu, HI 96805-2121

Or you may hand deliver to: EUTF, 201 Merchant Street, Suite 1520, Honolulu, HI 96813

Customer Service Call Center

Oahu (808) 586-7390
Toll Free 1(800) 295-0089