State of Hawaii Premium Conversion Plan

 Election Change Form

This form must be received by your employing department within 90 days of a qualifying event.

Changes/cancellations must be consistent with the event indicated and shall become effective on a prospective basis from the employer’s receipt date. NOTE: Changes/cancellations for DOMESTIC PARTNERS can only be made during the annual Open Enrollment Period.

1. Name (Last, First, Middle)
   2. Social Security Number (last 4-digits)
   3. BU Code
   4. Department
   5. Division or School
   6. Business Phone
   7. Date of Qualifying Event

PART A: Please check the benefits plan affected:

- Medical/Prescription Drug/Chiropractic
- Drug Only Plan
- Vision Plan
- Dental Plan

PART B: Action requested: Select box 1, 2, or 3 and the corresponding change in personal status.

1. I elect to TERMINATE my participation in the Premium Conversion Plan due to:
   - Open Enrollment
   - My transfer to a non-eligible employment classification
   - My loss of eligibility for coverage under a component plan
   - I will be covered under my new second employer’s health benefits plan or a new health benefits plan offered by my second employer
   - My marriage. I will be covered under my spouse’s employer’s plan
   - I will be covered as a dependent under my spouse’s new employer’s plan or retiree health benefits plan.
   - My spouse, who is also a State employee, changed his/her health plan enrollment to family coverage due to the birth/adoption of our child
   - I will be placed on a leave without pay status
   - Other (I have attached a written explanation)

2. I elect to CHANGE the amount of the PCP reduction of my pay from:
   - Self-Only to 2-party or Family enrollment; or
   - 2-party to Family enrollment because of:
     - Open Enrollment
     - My Marriage
     - Birth or adoption of my child(ren)
     - My eligible dependent (re-)joined my household
     - My dependent’s loss of eligibility for coverage under a health benefits plan
     - My spouse’s health benefits plan is significantly changed or terminated
     - Other

3. I elect to PARTICIPATE in the Premium Conversion Plan, Self-Only 2-party Family enrollment
   - My being out of State during the entire Open Enrollment Period
   - My return from a leave without pay status
   - My loss of health benefits plan coverage because of the involuntary termination of my enrollment or my spouse’s enrollment due to:
     - Death
     - Divorce/Annulment of my marriage
     - Eligibility/employment termination

PART C:
I understand that I am making an election that is binding for the remainder of the plan year. I also understand that during this period I may not modify my reduction in pay unless (1) the plan is terminated, (2) there is an increase in the amount of required employee contributions for the coverage which I have elected in conjunction with this current Election Change Form, or (3) there is a change in my personal status that qualifies under the Internal Revenue Code.

Employee Signature: ____________________________  Date: ____________________________