PERSONNEL OFFICE USE
Employer Receipt Date _ _ / _ _ / _ _
PCP Effective Date _ _ / _ _ / _ _
DPO Signature:

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.

1. Name (Last, First, Middle)	2. Social Security Number (last 4-digits) XXX-XX-_ _ _ _	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 ❑ 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) satisfies the eligibility requirements of the plan (e.g. full-time student, etc.)
- ❑ 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 _____

❑ **Family** to 2-party or Self-Only enrollment; or ❑ **2-party** to Self-Only because of:

- ❑ Open Enrollment
- ❑ My Divorce/annulment of my marriage
- ❑ Death of my dependent(s)
- ❑ My dependent(s) no longer satisfies the eligibility requirements of the plan (e.g., attainment of age, loss of student status, marriage, etc.)
- ❑ My spouse/dependent child becoming eligible for and electing coverage under another health benefits plan
- ❑ Other _____

❑ Change of health benefits plan insurance carrier because my new residence is out of the service area of my present carrier.

❑ Change to a new employment classification where other component plans have become available or where my carrier's plan is not available.

❑ 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 ❑Other_____

❑ 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: